

Print Applicant Name:(Last, First, MI.)

Date of Birth: (MM/DD/YYYY)

Section XI: (Optional) Applicant Consent - To be completed by the Applicant

Declined ☐

a. CONSENT FOR MEDICAL PRACTITIONER TO RELEASE INFORMATION TO THE COAST GUARD:

My signature below authorizes the Medical Practitioner, who has signed the certification on page 9 of this form, to release to, or discuss with authorized Coast Guard personnel, any pertinent information in his/her possession regarding any physical or medical condition that may require review by the Coast Guard prior to determining whether the Coast Guard should issue a merchant mariner medical certificate.

I understand that this authorization is voluntary. I also understand that failure to provide authorization could affect the Coast Guard's ability to make a timely determination as to whether the Coast Guard should issue me a merchant mariner medical certificate. This authorization will remain in effect until the Coast Guard determines whether to issue me the requested merchant mariner medical certificate for maritime service, but no longer than one year.

I have read and understand the following statement about my rights:

I may revoke this authorization at any time prior to its expiration date by notifying the verifying medical practitioner in writing, but the revocation will not have any effect on any actions taken before they received the notification.

Upon request, I may see or copy the information described in this release.

I am not required to sign this release to receive my medical evaluation.

Signature of Applicant

Date (MM/DD/YYYY)

b. CONSENT FOR COAST GUARD TO RELEASE INFORMATION TO A THIRD PARTY:

My signature authorizes the Coast Guard to share my medical information with the third party indicated below. I understand that I may revoke this authorization at any time prior to its expiration date by notifying the Coast Guard in writing.

Please provide the Name of the Organization or Third Party, Address, and Phone Number. Additional Third Party Authorization information may be attached separately.

Send Medical Credential to Mariners' address on page 3

Name of Organization or Third Party

Organization Point of Contact (if applicable)

Phone Number

Street Address

City

State

Zip Code

Signature of Applicant

Date (MM/DD/YYYY)

c. CONSENT FOR THIRD PARTY TO ACT ON MY BEHALF:

My signature authorizes the following third party **to act on my behalf** in all matters pertaining to the processing of my current application for a medical certificate. This means that the Coast Guard will share my medical information and correspond with the third party, and it means that the third party can request agency action on my behalf, and receive my medical certificate.

I understand that I may revoke this authorization at any time prior to its expiration date by notifying the Coast Guard in writing.

Please provide the Name of the Organization or Third Party, Address, and Phone Number. Additional Third Party Authorization information may be attached separately.

Name of Organization or Third Party

Organization Point of Contact (if applicable)

Phone Number

Street Address

City

State

Zip Code

Signature of Applicant

Date (MM/DD/YYYY)