



THE REPUBLIC OF TRINIDAD AND TOBAGO  
MARITIME SERVICES DIVISION

**MEDICAL FITNESS CERTIFICATE**  
*Issued under the Shipping (Medical Examination) Regulations, 1990*

Seafarer's Name ..... Discharge Book No. ....

Date of expiry of this

Certificate.....

I certify that I have examined the seafarer named above to the Medical and Visual Standards of Trinidad and Tobago as contained in the Third and Fourth Schedules of the above-named Regulations and have found \*him/her fit for seafaring subject to the following restrictions:

Signed.....  
*(A registered medical practitioner approved by the Minister)*

Date of Examination.....



*\*Delete as appropriate*



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5. Medical Examination

Does the seafarer suffer from any of the following abnormalities?

Please tick correct box and expand as necessary

- Tooth
- ENT
- Skin
- Heart
- Lungs
- Nervous system
- Varicose veins
- Genito urinary system
- Hernia

Any other defects.....

6 Height (without shoes).....m .....cm  
 Weight (stripped to waist).....kilos  
 Chest Inspiration .....cm  
 Expiration.....cm  
 Pulse rate.....

Eye test  
 Blood pressure systolic.....  
 5th Sound.....

Results of urine test  
 Albumin.....  
 Sugar.....

Audiogram (if equipment is available)

Right ear

KhZ dB	500	1,000	2,000	4,000	6,000	8,000
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Left ear

KhZ dB	500	1,000	2,000	4,000	6,000	8,000
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Distant vision

Unaided	R 6		L 6		Both 6	
Aided	R 6		L 6		Both 6	

Near vision

Unaided N
Aided N

Colour vision

Ishihare Engineers modified	
Normal	Defective

7. Results of Medical Examination

The Standards of Medical Examination Regulations have been or have not been met.

Tick correct box

- A** Unrestrictive sea service
- B** Restriction service only
- Restriction.....
- Period of restriction.....
- C** Temporarily   
(Review in.....months)
- D** Indefinitely   
(Review in.....months)
- E** Permanently

Medical Practitioner's  
 Official Stamp

Signature.....

Name.....

*B/lock*

Date.....