

MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD

SURNAME:	GIVEN NAME (S):		
DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH CITY COUNTRY	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
POSITION ON BOARD: MASTER <input type="checkbox"/> DECK OFFICER <input type="checkbox"/> ENGINEERING OFFICER <input type="checkbox"/> RADIO OPERATOR <input type="checkbox"/> RATING <input type="checkbox"/>	MAILING ADDRESS OF APPLICANT:		

DECLARATION OF THE AUTHORIZED PHYSICIAN

VISION		COLOR TEST TYPE		HEARING
	WITHOUT GLASSES	WITH GLASSES		
RIGHT EYE	_____	_____	<input type="checkbox"/> BOOK	RIGHT EAR _____
			<input type="checkbox"/> LANTERN	
			YELLOW _____ RED _____	
LEFT EYE	_____	_____	GREEN _____ BLUE _____	LEFT EAR _____

Confirmation that identification documents were checked at the point of examination: YES NO

Hearing meets the standards in STCW Code, Section A-1/9? YES NO NOT APPLICABLE

Unaided hearing satisfactory? YES NO

Visual acuity meets standards in STCW Code, Section A-1/9? YES NO

Colour vision meets standards in STCW Code, Section A-1/9? YES NO
(the visual test it is required every six years)

Date of the last colour vision test: (Day/Month/Year) ____ / ____ / ____ .

Are glasses or contact lenses necessary to meet the required vision standards? YES NO

Able for watchkeeping? YES NO

Is applicant taking any non-prescription or prescription medications? YES NO

Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarers unfit for such service or to endanger the health of other persons on board? YES NO

Hereby I declare that I am in knowledge of the contents of the Physical Examination.

 Signature of Applicant Name of Applicant Date

CIRCLE APPROPRIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFICER / ENGINEERING OFFICER / RADIO OPERATOR / RATING) (WITHOUT ANY / WITH THE FOLLOWING) RESTRICTIONS:

NAME AND DEGREE OF PHYSICIAN: _____

ADDRESS: _____

NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: _____

DATE OF ISSUE PHYSICIAN'S CERTIFICATE: _____

SIGNATURE OF PHYSICIAN: _____	STAMP OF PHYSICIAN: _____	DATE: _____
-------------------------------	---------------------------	-------------

EXPIRY DATE OF CERTIFICATE: _____

This certificate is issued in compliance with the requirements of the STCW Convention, 1978, as amended and the Maritime Labour Convention, 2006.