This Seafarer Medical Certificate complies with STWC 1/9 or ILO-73 and Bahamian and Maltese Medical Standards or as approved by Countries with a Reciprocal Recognition Agreement, "Guidance for conducting Medical Fitness Examination for Seafarers"

EMPLOYMENT MEDICAL EXAM FORM A

(New and Returning Crew)

Family Name:	Given Name:		Gender: ☐ Male ☐ Female	Birth Date (day/month/year):	Crew Position:
Seaman's Book No.:	Crew I.D. No.:	ID Confirmed? ☐ Yes ☐ No	Passport No.:		Nationality:
City of Residence:	Country of Residence:	Vessel:	Type of Ship: ☐Container ☐Tanker ☐Passenger ☐Fishing		Trade Area: ☐Coastal ☐Tropical ☐Worldwide

DO YOU HAVE OR DID YOU EVER HAVE ANY OF THE FOLLOWING CONDITIONS?

	CONDITION	Yes	No
1.	Frequent Ear Infections		
2.	Hearing Loss / Hearing aids		
3.	Glaucoma		
4.	Conjunctivitis		
5.	Do you wear glasses / contact lenses		
6.	Eye injury / Eye Problems		
7.	Frequent Colds / Sinus Trouble		
8.	Viral/Mononucleosis/Chicken Pox/ Measles/Mumps		
9.	Nosebleed		
10.	Frequent Sore Throat		
11.	Swollen Glands		
12.	Asthma or Wheezing		
13.	Bronchitis		
14.	Tuberculosis (TB)		
15.	Pneumonia		
16.	Coughing up Blood		
17.	Shortness of Breath		
18.	Rheumatic Fever		
19.	Hepatitis: A ☐ B ☐ C ☐		
20.	High Blood Pressure		
21.	Chest Pain		
22.	Heart Attack / Angina / Irregular heart beat		
23.	Poor Circulation / Varicose veins		
24.	Other Heart Disease		
25.	Heart Surgery		
26.	Blood Disorder		
27.	Kidney Problem		
28.	Infections/Contagious diseases		
29.	Hernia		
30.	Attempted Suicide		
31.	Genital Disorders		
32.	Sleep Problems		
33.	Psychiatric Problems		
34.	Loss of Memory		
35.	Stroke		
36.	Abdominal Pain		
37.	Gastritis / Reflux / Gastric or Duodenal Ulcer		
38.	Frequent Diarrhea or Constipation		
39.	Bleeding from Stomach or Bowels		
40.	Jaundice / Gallbladder / Liver Problems		
41.	Do you feel healthy and fit to perform the duties of your designated position/occupation?		
42.	Hemorrhoids / rectal bleeding		
43.	Urinary infection / blood in urine/ kidney stones		
44.	Prostate Disease (males)		
45.	Hernias of any kind		

	CONDITION	Yes	No
46.	Syphillis / HIV / Gonorrhea		
47.	Breast Mass / Lumps /Tenderness		
48.	Skin problems / Rashes		
49.	Allergies/anaphylaxis to environment, chemicals, food or drugs		
50.	Hand or Wrist Pain / Problem		
51.	Joint Pains / Arthritis / Numbness in Extremities		
52.	Elbow Pain / Injury / Surgery		
53.	Shoulder Pain / Injury / Surgery		
54.	Knee Pain / Injury / Surgery		
55.	Feet Pain / Injury / Surgery		
56.	Sprains / Dislocations / Fractures		
57.	Neck Pain/ Scoliosis / Cervical Injury		
58.	Back pain / Injury / Sciatica		
59.	Amputations, prosthetics		
60.	Headaches / Dizziness / Loss of Consciousness / Migraines		
61.	Head Injury or Concussion		
62.	Seizures / Epilepsy / Receiving Medications for it		
63.	Nervous Breakdown / Depression /Anxiety		
64.	Muscular Weakness		
65.	Yellow Fever / Scarlet Fever / Malaria / Tropical Diseases		
66.	Cancer or tumors		
67.	Serious Accidents / Illness		
68.	Thyroid Disease		
69.	Balance Problem		
70.	Throat Problems		
71.	Restricted Mobility		
72.	Fractures/Dislocations		
73.	Diabetes / Type I ☐ II ☐		
75.	Have you signed off as sick or repatriated from a ship?		
76.	Have you ever been **Hospitalized**? For What?		
77.	Have you ever been declared unfit for sea duty?		
78.	Has your medical certificate ever been restricted or revoked?		
79.	Have you had **ANY** type of surgery?		
80.	Have you ever received a blood transfusion? Why?		
81.	Are you taking **ANY** medications? What?		
82.	Alternative Medicine or Treatment? What?		
83.	Do you drink alcohol? How much per day: _____ week: _____		
84.	Do you smoke? If yes, how much per day? _____		
85.	Are you aware that you have any medical problems, diseases, Illnesses?		

FEMALES:

86.	Are you or do you think you may be pregnant?		
87.	What was the date of your last menstrual period? _____		
88.	Gynecological / Female Problems		

TO BE COMPLETED BY PHYSICIAN ***ALL "YES" RESPONSES ABOVE REQUIRE COMMENTS FROM THE EXAMINING PHYSICIAN IN ENGLISH***

Question #:	Comments:

MEDICAL CONSENT/AUTHORIZATION/RELEASE

My signature below acknowledges that all statements provided by me in this application are true and correct to the best of my knowledge and belief, and I further authorize and consent to the release of any/all of my medical records from any source, including nations, insurance offices, doctors, hospitals, and/or other institutions or public authorities. This general medical release will also authorize the release of any/all of my psychological or psychiatric records or referrals. I UNDERSTAND THAT FALSIFICATION WILL BE GROUNDS FOR LOSS OF BENEFITS AND/OR TERMINATION OF EMPLOYMENT. My signature further acknowledges my consent to any/all physical examinations and diagnostic testing:

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

SIGNATURE OF EXAMINEE	DATE	WITNESS NAME *(please print)*	WITNESS SIGNATURE	DATE

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. _____ **(**approved medical examiner).

SIGNATURE OF EXAMINEE	DATE	WITNESS NAME *(please print)*	WITNESS SIGNATURE	DATE

I acknowledge that I have reviewed the above information with the Applicant and noted Comments as required. Physician Phone #: _____

PHYSICIAN SIGNATURE	PHYSICIAN NAME *(please print)*	PHYSICIAN PHONE NUMBER	DATE

FOR RCL OFFICE USE ONLY		
Reviewed by NAME *(please print)*	SIGNATURE	DATE