

MEDICAL CERTIFICATE FOR SERVICE AT SEA

SURNAME/LAST NAME:			GIVEN/FIRST NAME:			MIDDLE NAME:			
Age:	Date of Birth: DAY MONTH YEAR			Place of Birth:			Nationality:		
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>			Civil Status: Single <input type="checkbox"/> Married <input type="checkbox"/>			Religion:			
Address:									
Passport Number:					Seaman's Book Number:				
Position on Board: <input type="checkbox"/> DECK <input type="checkbox"/> ENGINE <input type="checkbox"/> CATERING <input type="checkbox"/> OTHER Specify:						Company:			
DECLARATION OF THE AUTHORIZED PHYSICIAN									
CONFIRMATION THAT IDENTIFICATION DOCUMENTS WERE CHECKED AT THE POINT OF EXAMINATION							YES <input type="checkbox"/>		NO <input type="checkbox"/>
HEARING MEETS THE STANDARDS IN STCW CODE, SECTION A-1/9?							YES <input type="checkbox"/>		NO <input type="checkbox"/>
UNAIDED HEARING SATISFACTORY?							YES <input type="checkbox"/>		NO <input type="checkbox"/>
VISUAL ACUITY MEETS STANDARDS IN STCW CODE, SECTION A-1/9?							YES <input type="checkbox"/>		NO <input type="checkbox"/>
COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-1/9? Date of last colour vision test: (Day / Month / Year)							YES <input type="checkbox"/>		NO <input type="checkbox"/>
VISUAL AIDS (tick if worn)						SPECTACLES <input type="checkbox"/>		CONTACT LENSES <input type="checkbox"/>	
FIT FOR LOOKOUT DUTIES?							YES <input type="checkbox"/>		NO <input type="checkbox"/>
FIT BUT AT RISK? If "AT RISK" specify limitations or restrictions:							YES <input type="checkbox"/>		NO <input type="checkbox"/>
PASSPORT PHOTO			THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION IN ACCORDANCE WITH WEST OF ENGLAND RECOMMENDED PROTOCOLS HAS BEEN CARRIED OUT						
			NAME OF SEAFARER:						
			RESULT: FIT FOR DUTY: <input type="checkbox"/> FIT BUT AT RISK: <input type="checkbox"/> UNFIT FOR DUTY: <input type="checkbox"/>						
			Name and Signature of Examining Authorized Physician:						
			Date of Examination: (Day / Month / Year)						
Approved by:									
Title:									
NAME OF CLINIC:			ADDRESS:						
PHYSICIAN'S CERTIFYING AUTHORITY:			PHYSICIAN'S LICENSE NUMBER:						
I HAVE READ AND UNDERSTOOD AND WAS INFORMED OF THE CONTENTS OF THE CERTIFICATE AND OF THE RIGHT TO A REVIEW IN ACCORDANCE WITH PARAGRAPH 6 OF SECTION A-1/9 OF THE STCW CODE.									
Seafarer's Name and Signature:						Date:			
(This signature should be affixed in the presence of the examining physician)									
Date of Issuance: DAY MONTH YEAR			Date of Expiration: DAY MONTH YEAR						
<input type="text"/> <input type="text"/> <input type="text"/>			<input type="text"/> <input type="text"/> <input type="text"/>						