Seafarers Self Declaration Form

Uberrima fides

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:

DO YOU HAVE, DID YOU EVER HAVE OR HAVE YOU BEEN TOLD YOU HAVE: (to be completed by crew member)

IF YOU ANSWER "Yes" TO ANY OF THE QUESTIONS IN THIS SECTION, PLEASE PROVIDE AN EXPLANATION ON THE NEXT PAGE.

If you do not understand any terms you must ask your medical provider to explain.

	CONDITION	Yes	No
1.	Do you feel healthy and fit to perform the duties of your designated position/occupation? If "No" specify below:	☐	☐
	Explanation:		
2.	Have you ever been declared unfit for sea duty?	☐	☐
3.	Has your medical certificate ever been restricted or revoked?	☐	☐
4.	Have you signed off as sick or repatriated from a ship?	☐	☐
5.	Are you aware that you have any medical problems, diseases or illnesses?	☐	☐
6.	Do you drink alcohol? How much per day_____week_____	☐	☐
7.	Do you smoke? How many years? How much per day?	☐	☐
8.	Have you ever been **Hospitalised**? For What? When?	☐	☐
9.	Have you had **ANY** type of surgery? For What? When?	☐	☐
10.	Have you ever received a blood transfusion? Why?	☐	☐
11.	Are you taking **ANY** medications?	☐	☐
12.	Alternative Medicine or Treatment? What?	☐	☐
PSYCHIATRIC			
13.	Attempted Suicide?	☐	☐
14.	Ever had thoughts of Harming Self or Others?	☐	☐
15.	Psychiatric Problems/Bipolar/Other Disorders?	☐	☐
16.	Nervous Breakdown/Depression/Anxiety?	☐	☐
17.	Attention deficit/hyperactivity disorder (ADHD)?	☐	☐
18.	Difficulty Concentrating on Things?	☐	☐
19.	Trouble Falling Asleep, Staying Asleep or Sleeping too much?	☐	☐
ORTHOPEDIC			
20.	Neck Pain/Scoliosis/Cervical Injury/Radiating Pain?	☐	☐
21.	Back Pain/Injury/Sciatica/Radiating Pain?	☐	☐
22.	Hand/Wrist Pain or Numbness?	☐	☐
23.	Elbow Pain/Injury/Surgery?	☐	☐
24.	Shoulder Pain/Injury/Surgery?	☐	☐
25.	Knee Pain/Injury/Surgery/Osteoarthritis?	☐	☐
26.	Feet Pain/Numbness/Tingling/Injury/Surgery/Heel Pain?	☐	☐
27.	Sprains/Dislocations/Fractures?	☐	☐
INFECTIOUS DISEASES			
28.	Rheumatic Fever (autoimmune)?	☐	☐
29.	Infectious/Contagious Diseases?	☐	☐
30.	Syphilis/HIV/Gonorrhea/Other Sexually Transmitted Disease?	☐	☐
31.	Hepatitis: A ☐ B ☐ C ☐ ?	☐	☐
32.	Tuberculosis (TB)? Date____/____/____	☐	☐
33.	Yellow Fever/Scarlet Fever/Malaria/Tropical Diseases?	☐	☐
34.	Viral/Mononucleosis/Chicken Pox/Measles/Mumps?	☐	☐

	CONDITION	Yes	No
CARDIAC			
35.	Chest Pain? Palpitations?	☐	☐
36.	Heart Attack/Irregular Heart Beat/Rate?	☐	☐
37.	Heart Disease?	☐	☐
38.	Heart Surgery/Pacemaker/ICD Implantable (cardiac defibrillator)?	☐	☐
39.	High Blood Pressure? Date of Diagnosis:____/____/__	☐	☐
ENDOCRINOLOGY			
40.	Diabetes? ☐ Type Unknown ☐ Type I ☐ Type II	☐	☐
41.	Thyroid (weight loss, sweats, tremors) or Other Endocrine Disorders?	☐	☐
GASTROENTEROLOGY			
42.	Gastritis/Reflux/Gastric or Duodenal Ulcer?	☐	☐
43.	Frequent Diarrhoea or Constipation/Straining/Pain?	☐	☐
44.	Bleeding from Stomach or Bowels?	☐	☐
45.	Haemorrhoids/Rectal Bleeding?	☐	☐
46.	Jaundice (Yellow Eyes/Skin)/Gallbladder/Liver Problems	☐	☐
47.	Hernias of Any Kind/Hernia Surgery?	☐	☐
48.	Abdominal Pain?	☐	☐
PULMONARY			
49.	Asthma or Wheezing?	☐	☐
50.	Bronchitis?	☐	☐
51.	Pneumonia?	☐	☐
52.	Coughing Up Blood?	☐	☐
53.	Pulmonary Embolism?	☐	☐
54.	Shortness of Breath?	☐	☐
55.	Sleep Apnea?	☐	☐
NEUROLOGY			
56.	Headaches/Dizziness/Loss of Consciousness?	☐	☐
57.	Head Injury or Concussion?	☐	☐
58.	Fainting?	☐	☐
59.	Seizures/Epilepsy/Receiving Medications for Either?	☐	☐
60.	Loss of Memory?	☐	☐
61.	Stroke/Mini-Stroke (TIA)?	☐	☐
62.	Muscular Weakness?	☐	☐
BLOOD DISORDERS			
63.	Anaemia/Sickle Cell Anaemia?	☐	☐
64.	Hemophilia?	☐	☐
65.	Leukaemia?	☐	☐
66.	Other Blood Disorders?	☐	☐
UROLOGY			
67.	Kidney Problems/Dialysis?	☐	☐
68.	Bladder Infection/Blood in Urine/Kidney Stones?	☐	☐
69.	Prostate Disease (Males)?	☐	☐

	CONDITION	Yes	No
OPHTHALMOLOGY			
70.	Glaucoma?	☐	☐
71.	Conjunctivitis?	☐	☐
72.	Do you wear glasses/contact lenses?	☐	☐
73.	Eye Injury/Eye or Vision Problems?	☐	☐
74.	Cataracts?	☐	☐
75.	Macular Degeneration History?	☐	☐
76.	Eye Surgery?	☐	☐
77.	Colour Blindness?	☐	☐
EAR, NOSE & THROAT			
78.	Frequent Ear Infections?	☐	☐
79.	Hearing Loss/Hearing Aids?	☐	☐
80.	Frequent Colds/Sinus Trouble?	☐	☐
81.	Nose Bleed (Adulthood)?	☐	☐
82.	Frequent Sore Throat/Throat Problems or Hoarseness?	☐	☐
83.	Balance Problem/Meniere's Disease/Vertigo/Spinning Sensation?	☐	☐
DERMATOLOGY			
84.	Skin Problems/Rashes?	☐	☐
85.	Skin Cancer or Tumours?	☐	☐
86.	Dermatitis?	☐	☐
87.	Psoriasis/Eczema?	☐	☐
RHEUMATOLOGY			
88.	Lupus?	☐	☐
89.	Sarcoid Disease?	☐	☐
90.	Rheumatoid Arthritis?	☐	☐
91.	Joint Pains/Arthritis/Numbness in Extremities?	☐	☐

	CONDITION	Yes	No
ALLERGIES			
92.	Allergies, Anaphylaxis to Environment, Chemicals, Food/Drugs	☐	☐
VASCULAR			
93.	Varicose Veins/Varicose vein surgery?	☐	☐
94.	Poor Circulation?	☐	☐
95.	Gout?	☐	☐
MISCELLANEOUS			
96.	Serious Accidents/Illnesses?	☐	☐
97.	Swollen Glands?	☐	☐
98.	Restricted Mobility?	☐	☐
99.	Implants?	☐	☐
100.	Cancer of any kind (malignant or benign or in remission)?	☐	☐
GYNAECOLOGY – FEMALE ONLY			
101.	Are you or do you think you may be pregnant?	☐	☐
102.	What was the date of your last menstrual period?___/___/__	☐	☐
103.	Abnormal Vaginal Bleeding?	☐	☐
104.	Gynaecological/Female Problems?	☐	☐
105.	Fibroids/Ovarian Cyst?	☐	☐
106.	Frequent Bladder Infections?	☐	☐
107.	Ectopic Pregnancy?	☐	☐
108.	Breast Mass/Lumps/Tenderness? Date of Last Mammogram/Breast Ultrasound____/____/____	☐	☐

CREW MEMBER SECTION: (to be completed by crew member)

ALL "YES" RESPONSES ABOVE REQUIRE COMMENTS (IN ENGLISH) FROM THE CREW MEMBER AND MUST BE REVIEWED BY PHYSICIAN

Question:	Comments:

Crew Member Section Reviewed and Initiated by Physician _____

CERTIFICATION

By signing the below, I hereby certify that the information contained in this form is true, correct, and complete to the best of my knowledge and belief. I understand that any false information, misrepresentation, or omission of facts in this form are grounds for loss of benefits (including without limitation, medical benefits, sick pay, maintenance, death benefits, and disability benefits), disqualification from further consideration, and/or immediate termination of employment without recourse.

SIGNATURE OF EXAMINEE:
……

DATE:
……

WITNESS NAME:
……

WITNESS SIGNATURE:
……

DATE:
……

AUTHORISATION FOR USE AND DISCLOSURE OF INFORMATION

I understand the purpose of this examination is for West of England in accordance with West of England's PEME program:

- To obtain information that may be used to determine fitness for duty and/or
- To comply with legal or other reporting obligations, and/or
- To investigate any pre-existing disease.
- To assert or defend against legal claims.

To achieve the above purposes, I hereby request and authorise The Marine Advisory Medical Service to release all relevant medical records and information from any source, including hospitals, clinics, labs, physicians, psychologists, employers, insurance companies, government authorities, and any other health professionals, health institutions, or public authorities (collectively, 'Medical Records') to any Marine Advisory Medical Service medical personnel, any third party performing medical record review, and any other person or entity necessary for The Marine Advisory Medical Service to determine or verify whether I am fit for duty in accordance with the enhanced criteria.

In the event I make a claim for medical benefits, sick pay, death, or disability benefits, or any other benefit, I further authorise The Marine Advisory Medical Service to release any relevant Medical Records to West of England, the ship owner or manning agency personnel to make a claim determination or resolve a claim dispute or appeal. I authorise the release of all my Medical Records to the physician(s) performing the medical examination subject of this form.

I hereby authorise the release of my medical records, including patient history, office notes, test results, radiology studies, films, referrals, consultants and billing records, even if said record(s) include information related to alcohol, drug abuse, mental health treatment, or confidential HIV related information, to all parties aforementioned.

Further, I acknowledge that my Medical Data might be transferred to countries inside or outside the European Union (EU) and/or the European Economic Area (EEA). When we transfer your Medical Data outside the EU/EEA, the laws and rules that protect your Medical Data in such countries may be different (or less protective) from your own country.

Your consent declaration is completely voluntary, and you may, as well, revoke it at any time. The withholding or revocation of your consent will not have any negative, especially no disciplinary, consequences. However, your employer or manning agency might not be able to assign you to certain tasks that require an approved level of fitness if you withhold or withdraw your consent. If you revoke your consent, this will not impact the legitimacy of the previous use of your data that was based on your initial declaration of consent. The Marine Advisory Medical Service is the controller of the said data. You may revoke your consent by email to admin@marinemed.co.uk. If there is another legal basis for processing, The Marine Advisory Medical Service reserves the right to process the data on such other legal basis. You may also request access the data which we hold, which will be made available to you on request.

My signature below signifies that, to the best of my knowledge and belief, all information, answers and responses provided to the company, or company designated physicians, laboratory or medical staff, are true and correct. I fully understand that if I falsify or withhold relevant medical information or condition(s) and/or fail to provide West of England or its medical advisors, with updated information as necessary subsequent to the date of this document, such action or inaction may serve as grounds for termination of my employment without employment benefits. I also authorise release of any/all medical information concerning my past, present or future medical condition(s), by any medical practitioner or provider, to West of England and its medical advisors or its authorised representative. I am able to read, write and speak English and fully understand all of the above information.

SIGNATURE OF EXAMINEE:
……

DATE:
……

WITNESS NAME:
……

WITNESS SIGNATURE:
……

DATE:
……

ACKNOWLEDGEMENT BY PHYSICIAN

I acknowledge that I have reviewed the information contained in this form with the Applicant and noted Comments as required.

PHYSICIAN SIGNATURE:
……

PHYSICIAN NAME (please print):
……

PHYSICIAN PHONE NUMBER:
……

DATE:
……