SEAFARERS' MEDICAL FITNESS EXAMINATIONS FORM

IMPORTANT – Before completing this form, please ensure you have read the guidance notes and instructions on page 4

Part A : to be completed by the candidate

1- Personal details

Name:			االس..م ال.ثالث.ي:
Surname:			القبي.ل.ة:
Date of birth:	Place of birth:	مكان امليالد:	تاريخ اليالد:
Country of birth:	Nationality:	الجن.سية:	بلد امليالد:
Father's name:			اسم األب:
Nationality identity No:			الرقم امل.دني:
Home address:			عنوان املنزل:
Telephone No.	Mobile No.	Email:	

2. Medical condition declarations

Have you ever had any of the following conditions?

No.	Conditions	Yes	No	No.	Conditions	Yes	No	No.	Conditions	Yes	No
1	Eye/vision problem			2	High blood pressure			3	Heart/vascular disease		
4	Heart surgery			5	Varicose veins/piles			6	Asthma/bronchitis		
7	Blood disorder			8	Diabetes			9	Thyroid problem		
10	Digestive disorder			11	Kidney problem			12	Skin problem		
13	Allergies			14	Hernia			15	Genital disorder		
16	Infectious/contagious diseases			17	Do you smoke, use alcohol or drugs?			18	Ear (hearing, tinnitus)/ nose/ throat problem		
19	Pregnancy			20	Sleep problem			21	Operation/surgery		
22	Epilepsy/seizures			23	Dizziness/fainting			24	Loss of consciousness		
25	Psychiatric problems			26	Depression			27	Attempted suicide		
28	Loss of memory			29	Balance problem			30	Severe headaches		*
31	Restricted mobility			32	Back or joint problem			33	Amputation		
34	Fractures/dislocations										

If answer is "yes" to any of the above questions, please specify details:

3. Additional questions

No.	Questions	Yes	No	No.	Question	Yes	No
1	Have you ever been signed off as sick or repatriated from a ship?			2	Has your medical certificate even been restricted or revoked?		
3	Have you ever been hospitalized?			4	Have you ever been declared unfit for sea duty?		
5	Are you aware that you have any medical problems, diseases or illnesses?			6	Do you feel healthy and fit to perform the duties of your designated position/occupation?		
7	Are you allergic to any medication?			8	Are you taking any non-prescription or prescription medications?		

Comments:

If examinee is taking any non-prescription or prescription medications, please list the medications taken, and the purpose(s) and dosage(s):

4. Declaration and signature

I declare that the data contained in sections A.1 to A.3 of this application is a proper reflection of my answers and to the best of my knowledge, true and complete. I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to (the recognized medical practitioner).

Date and contact details for previous medical examination (if known): ....

....
Signature of candidate

....
Date

Part B : For the Medical practitioner use only

Candidates file No:

1- Sight:

Use of glasses or contact lenses:
if yes, specify which type and for what purpose; Yes ☐ No ☑

Visual acuity;	Unaided			Aided		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant	Normal	Normal	Normal			
Near	Normal	Normal	Normal			

Visual fields: Right eye: Normal ☑ Defective ☐ Left eye: Normal ☑ Defective ☐

Colour vision: Not tested ☐ Normal ☑ Doubtful ☐ Defective ☐

2- Hearing:

Pure tone and audiometry(dB)		500 Hz	1000 Hz	2000 Hz	3000 Hz
	Right ear	db	db	db	db
	Left ear	db	db	db	db

Speech and whisper test		Normal	Whisper
	Right ear	Normal	Normal
	Left ear	Normal	Normal

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3- Clinical findings:

BMI:

Height (cm): Weight (kg): Pulse rate: Rhythm: Normal

Blood pressure(mm Hg); Systolic: Diastolic:

Urinalysis; Glucose: Negative Protein: Negative RBS/FBS:

Condition	Normal	Abnormal	Condition	Normal	Abnormal
Head	*		Sinuses, nose, throat	*	
Mouth/teeth	*		Ears (general)	*	
Tympanic membrane	*		Eyes	*	
Ophthalmoscopy	*		Pupils	*	
Eye movement	*		Lungs and chest	*	
Breast examination	*		Heart	*	
Skin	*		Varicose veins	*	
Vascular (inc. pedal pulses)	*		Abdomen and viscera	*	
Hernia	*		Anus (not rectal exam)	*	
G-U system	*		Upper and lower extremities	*	
Spine (C/S, T/S and L/S)	*		Neurologic (full/brief)	*	
Psychiatric	*		General appearance	*	

4- Chest X-ray:

Not performed ☑ Performed on :

Results:

5- Other diagnostic test(s) and result(s):

Test	Result
Test: Spirometry	Result: Normal
Test:	Result:
Test:	Result:

6- Medical practitioner's comments and assessment of fitness, with reasons for any limitations:

Fit without restrictions or conditions;

Able to perform all duties worldwide within designated department

7- Assessment of fitness for service at sea

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the candidate medically:

Fit for lookout duty ☑ Not fit for lookout duty

	Deck service	Engine service	Catering service	Other services
Fit	☑	☑		
Unfit				

Without restrictions	With restriction	Visual aid required	Visual aid not required
☑			☑

Describe restrictions (e.g. specific position, type of ship, trade area), if any:

8- Specifications of the medical fitness certificate issued	Certificate number	Date of issue	Date of expiry

Dr. Farzad Saeid	……………………………………….	……………………….
Medical practitioner name	Signature of Medical practitioner	Date

GUIDANCE NOTES FOR THE EXAMINEE BEFORE COMPLETION OF PART A OF THIS FORM

Please complete this form in BLOCK LETTERS and in black ink.

1- Personal details

Enter your personal details in the boxes provided. Your name should be given IN FULL, and should be given in the same format as appears in your passport or other national identity document.

Your date of birth should be given in the format DD/MM/YYYY, e.g. 18 February 1960 would be written 18/02/1960.

You should give your permanent home address, where you are normally resident. You may also provide an alternative address for return of documents or correspondence relating to this application.

2 and 3- Medical condition declarations and Additional questions

Please carefully reply to the questions asked by the medical practitioner and provide detail when your answer to any question asked is yes.

If you are taking any non-prescription or prescription medications, please specify the medications taken, and the purpose(s) and dosage(s).

Please be aware of that in cases of wrong declaration or concealing information you may not only endanger your life at sea but also waiver your medical protection, including insurance, as stipulated in your contractual agreement.

4 – Declaration and signature

Please read the declaration. Once you are sure that the information you have given is, to the best of your knowledge, true and complete, and that the documents (if any) submitted are genuine, given and signed by the persons whose names appear on them, you should sign the declaration with your usual signature, including the date.

ANNEX 5

Format for Seafarers' medical fitness certificate

Seafarers' Medical Fitness Certificate

Certificate number:

This is to certify that ……………………………….……….born…………..of.............................nationality gender.................was examined in accordance with the Seafarers' medical fitness standards and certification requirements established in accordance with the provisions of the 1978 STCW Convention, regulation I/9 and found to be fit for service at sea, subject to any limitations indicated..

	Yes	No
Identification documents were checked	☐	☐
Hearing meets the standards	☐	☐
Unaided hearing satisfactory	☐	☐
Visual acuity meets standards	☐	☐
Colour vision meets standards	☐	☐
Fit for look- out duties	☐	☐
Seafarer free from any medical condition likely to endanger the health of other persons on board	☐	☐

Medical practitioner's
Name:

Signature:

Stamp:

Date of issue:	Date of expiry:

Limitations(if any):

Reference medical fitness examination form number:	I hereby confirm that I have been informed about the content of this certificate and my right to a review in accordance with the Ministerial directive for the qualifications and the certifications of seafarers, chapter 8, article 8. Signature of the seafarer:

1. This certificate is issued under the authority of the Ministry of Health and Ministry of Transport and Communications, Sultanate of Oman.
2. For verification purposes please contact either the issuing medical practitioner, at bellow address or, Seafarers' Affairs section, Directorate General of Maritime Affairs, Ministry of Transport and Communications, Sultanate of Oman, Fax: +968 24 694077,Email: seafarers@motc.gov.om

Address and contact details of the issuing medical establishment