CLINICOMED, INC.
MANILA
Medical & Laboratory Services

ISO 9001 BUREAU VERITAS Certification

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MEDICAL EXAMINATION REPORT FOR SEAFARERS

Approved and authorized by the Department Of Health (DOH) and the Maritime Industry Authority (MARINA) of the Republic of the Philippines
Issued in compliance with STCW Convention, 1978, as amended Section A-I/9 Paragraph 7 and the Maritime Labour Convention, 2006

SURNAME/LAST NAME:	**GIVEN NAME:**		**MIDDLE NAME:**
AGE:	**DATE OF BIRTH:**	**PLACE OF BIRTH:**	**NATIONALITY:**
GENDER:	**CIVIL STATUS:**		**RELIGION:**
ADDRESS:			
PASSPORT NUMBER:		**SEAMAN'S BOOK (SIRB) NUMBER:**	
POSITION APPLIED FOR:			
NAME OF COMPANY:			

I. MEDICAL HISTORY – Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions:
Place a check mark (✓) in the appropriate box

Head or Neck Injury	☐ YES ☐ NO	Other Lung Disorders	☐ YES ☐ NO	Gynaecological Disorders	☐ YES ☐ NO
Frequent Headaches	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Last Menstrual Period Specify date_____	☐ YES ☐ NO
Frequent Dizziness	☐ YES ☐ NO	Heart Disease/ Vascular / Chest Pain	☐ YES ☐ NO	Kidney or Bladder Disorder	☐ YES ☐ NO
Fainting Spells, Fits, Seizures or Other Neurological Disorders	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO	Back Injury/ Joint Pain / Arthritis	☐ YES ☐ NO
Insomnia or Sleep Disorders	☐ YES ☐ NO	Diabetes Mellitus	☐ YES ☐ NO	Genetic, Hereditary or Familial Disorders	☐ YES ☐ NO
Depression, other Mental Disorders	☐ YES ☐ NO	Other Endocrine Disorders (e.g. Goiter)	☐ YES ☐ NO	Sexually Transmitted Diseases	☐ YES ☐ NO
Eye Problems / Error of Refraction	☐ YES ☐ NO	Cancer or Tumor	☐ YES ☐ NO	Tropical Diseases (e.g. Malaria Typhoid Fever – Specify Date)	☐ YES ☐ NO
Deafness, Other Ear Disorders	☐ YES ☐ NO	Blood Disorders	☐ YES ☐ NO	Schistosomiasis(Specify date)	☐ YES ☐ NO
Nose or Throat Disorders	☐ YES ☐ NO	Stomach Pain, Gastritis Or Ulcer	☐ YES ☐ NO	Asthma	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO	Other Abdominal Disorders	☐ YES ☐ NO	Allergies (Specify)	☐ YES ☐ NO

Previous Hospitalization(s)/Operation(s):

Place a check mark (✓) in the appropriate box ☐

	YES	NO
1. Have you ever been signed off as sick or repatriated from a ship?	☐	☐
2. Have you ever been hospitalized?	☐	☐
3. Have you ever been declared unfit for sea duty?	☐	☐
4. Has your medical certificate ever been restricted or revoked?	☐	☐
5. Are you aware that you have any medical problem, disease or illness?	☐	☐
6. Do you feel healthy and fit to perform the duties of your designated position/occupation?	☐	☐
7. Are you allergic to any medication?	☐	☐
Comments: _____		
8. Are you taking any non-prescription or prescription medication?	☐	☐
If yes, Please list the medication(s) taken/being taken, and the purpose(s) and dosage(s): _____		

II. MEDICAL EXAMINATION
Enter the data called for. Place a check mark (✓) in the appropriate box ☐

HEIGHT (cm):	WEIGHT (kg):	BLOOD PRESSURE:	PULSE RATE:	RESPIRATION:		BMI:
VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION	EAR	Hearing by Audiometry	CLARITY OF SPEECH
Uncorrected			Adequate	Right	Adequate / Inadequate	Adequate
Corrected			Defective	Left	Adequate / Inadequate	Defective

II. MEDICAL EXAMINATION (Continuation). Alongside columns A, B, C, put a check mark (✓) under 'YES' if Normal. If not Normal, Specify findings.

A	YES	Significant Findings	B	YES	Significant Findings	C	YES	Significant Findings
Skin	☐		Neck Lymph Nodes, Thyroid	☐		Genito-urinary System	☐	
Head, neck, scalp	☐		Chest-Breast-Axilla	☐		Inguinals, Genitals	☐	
Eyes, external	☐		Lungs	☐		Extremities	☐	
Pupils, Ophthalmoscopic	☐		Heart	☐		Reflexes	☐	
Ears	☐		Abdomen	☐		Dental (Teeth/Gums)	☐	
Nose, Sinuses	☐		Back	☐				
Mouth, Throat	☐		Anus-rectum	☐				

III. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (✓) in the appropriate box ☐ .

A. CHEST X-RAY: ☐ NORMAL ☐ WITH FINDINGS	D. URINALYSIS: ☐ NORMAL ☐ WITH FINDINGS	G. HIV/AIDS Test: (when required) ☐ REACTIVE ☐ NON REACTIVE
B. ECG: ☐ NORMAL ☐ WITH FINDINGS	E. STOOL EXAM: (when required) ☐ NORMAL ☐ WITH FINDINGS	H. RPR and/or TPHA ☐ REACTIVE ☐ NON REACTIVE
C. CBC: ☐ NORMAL ☐ WITH FINDINGS	F. Hepatitis B: (when required) ☐ REACTIVE ☐ NON REACTIVE	I. BLOOD TYPE (Specify):

PSYCHOLOGICAL TEST (when required): ☐ NORMAL ☐ FOR FURTHER EVALUATION

ADDITIONAL TEST(S) (Specify): e.g. Blood Chemistries, Drug Test, Alcohol Test, Liver Function Test, Stool Culture, etc.

IV. SUMMARY. Place a check mark (✓) in the appropriate box ☐ .

Basic DOH Mandatory Medical Examination:	☐ PASSED	☐ WITH SIGNIFICANT FINDINGS
Additional Laboratory Tests:	☐ PASSED	☐ WITH SIGNIFICANT FINDINGS
Flag / Host Medical and Laboratory Requirements:	☐ PASSED	☐ WITH SIGNIFICANT FINDINGS

REMARKS/SPECIAL NEEDS (Specify e.g. with medication, diet restriction etc.)

V. ASSESMENT OF FITNESS FOR SERVICE AT SEA. Place a check mark (✓) in the appropriate box ☐ .

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

FIT FOR LOOK-OUT DUTY ☐ **NOT FIT FOR LOOK-OUT DUTY** ☐

	DECK SERVICE	ENGINE SERVICE	CATERING SERVICE	OTHER SERVICES
FIT	☐	☐	☐	☐
UNFIT	☐	☐	☐	☐

WITH RESTRICTIONS: ☐ **WITHOUT RESTRICTIONS:** ☐ **VISUAL AIDS REQURED: YES** ☐ **NO** ☐

DESCRIBE RESTRICTIONS **(REFER TO STANDARD RESTRICTIONS AT THE BOTTOM OF THIS PAGE)

DATE OF MEDICAL EXAMINATION:	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT:	MEDICAL EXAMINATION REPORT NO:

NAME AND SIGNATURE OF EXAMINING /AUTHORIZED PHYSICIAN: _____

LICENSE NUMBER: _____

ADDRESS:

_____

I hereby certify that the personal declaration above is true to the best of my knowledge and I fully understand the above results of my medical examination as explained to me by the examining/authorized physician.

I hereby authorize the release of all my medical records to the DOH/MARINA/POEA, the examining / authorized physician and my employer/manning agency (_____)

_____ _____

NAME AND SIGNATURE OF SEAFARER **DATE**

THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF EXAMINING PHYSICIAN

***STANDARD RESTRICTIONS (Duties):**

- *No solo watchkeeping*
- *Not fit for emergency duties*
- *Not fit for lookout duties*
- *Only fit for lookout during daylight hours*
- *Not fit for work with colour coded tables etc*
- *Not to be away from (home) port overnight*
- *Not to be away from (home)port for periods over 24 hours/7days*
- *Not to lift items weighing over 5/10/20/40kg*
- *Protective gloves to be worn for work with ……(specify)*
- *Eye protection to be worn for all work*
- *Not to work with…..(specify)*
- *Not fit for food handling*
- *Within….(specify)miles from a safe haven*
- *Near – coastal only*
- *Coastal waters only, up to…….(specify) miles from shore*
- *Non-tropical waters only*
- *Not fit for service on stand-by vessels*
- *Fit for service only on vessels with ship's doctor*
- *Toilet/washing facilities in private cabin required*
- *Special needs… in emergencies(specify)*