

## MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD

SURNAME:			GIVEN NAME (S):		
DATE OF BIRTH: DAY          MONTH          YEAR			PLACE OF BIRTH CITY                          COUNTRY		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
POSITION ON BOARD: MASTER <input type="checkbox"/> DECK OFFICER <input type="checkbox"/> ENGINEERING OFFICER <input type="checkbox"/> RADIO OPERATOR <input type="checkbox"/> RATING <input type="checkbox"/>			MAILING ADDRESS OF APPLICANT:		

### DECLARATION OF THE AUTHORIZED PHYSICIAN

	VISION		COLOR TEST TYPE	HEARING
	WITHOUT GLASSES	WITH GLASSES		
RIGHT EYE	_____	_____	<input type="checkbox"/> BOOK <input type="checkbox"/> LANTERN YELLOW _____ RED _____ GREEN _____ BLUE _____	RIGHT EAR _____
LEFT EYE	_____	_____		LEFT EAR _____

Confirmation that identification documents were checked at the point of examination: YES  NO

Hearing meets the standards in STCW Code, Section A-1/9? YES  NO  NOT APLICABLE

Unaided hearing satisfactory? YES  NO

Visual acuity meets standards in STCW Code, Section A-1/9? YES  NO

Colour vision meets standards in STCW Code, Section A-1/9? YES  NO   
(the visual test it is required every six years)

Date of the last colour vision test: (Day/Month/Year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ .

Are glasses or contact lenses necessary to meet the required vision standards? YES  NO

Able for watchkeeping? YES  NO

Is applicant taking any non-prescription or prescription medications? YES  NO

Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarers unfit for such service or to endanger the health of other persons on board? YES  NO

Hereby I declare that I am in knowledge of the contents of the Physical Examination.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Date

CIRCLE APPROPRIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFICER / ENGINEERING OFFICER / RADIO OPERATOR / RATING) (WITHOUT ANY / WITH THE FOLLOWING) RESTRICTIONS:

NAME AND DEGREE OF PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: \_\_\_\_\_

DATE OF ISSUE PHYSICIAN'S CERTIFICATE: \_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ | STAMP OF PHYSICIAN: \_\_\_\_\_ | DATE: \_\_\_\_\_

EXPIRY DATE OF CERTIFICATE: \_\_\_\_\_

*This certificate is issued in compliance with the requirements  
of the STCW Convention, 1978, as amended and the Maritime Labour Convention, 2006.*