| DOH ACCREDITATION NUMBER | **NAME OF CLINIC**<br>**ADDRESS**<br>**TEL NO., FAX, EMAIL ADDRESS** | SEAFARER MEDICAL CERTIFICATE<br>Control Number: |
|---|---|---|

| SURNAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| PLACE AND DATE OF BIRTH (dd/mm/yyyy) | PASSPORT NUMBER: | SEAMAN'S BOOK NUMBER: |

| NATIONALITY: | SEX: □ Male □ Female | Civil Status: □ Single □ Married | Religion: |
|---|---|---|---|

| PERMANENT HOME ADDRESS: | CONTACT NUMBER: |
|---|---|
| | POSITION APPLIED FOR: |

I. PAST MEDICAL HISTORY. Has applicant suffered from or been told he has any of the following: If Yes, tick (√) appropriate box (□).

| | | |
|---|---|---|
| □ Head or Neck Injury | □ Other Lung Disorders | □ Kidney or Bladder Disorder |
| □ Frequent Headaches | □ High Blood Pressure | □ Back Injury; Joint Pain/ Arthritis/ Rheumatism |
| □ Frequent Dizziness | □ Heart Disease/ Chest Pain | □ Genetic, Hereditary or Familial Disorders |
| □ Fainting Spells, Fits, Seizures or Other Neurological Disorders | □ Rheumatic Fever | □ Sexually Transmitted Diseases |
| □ Insomnia or Sleep Disorders, Manias, Phobias | □ Diabetes Mellitus | □ Tropical Diseases (e.g. Malaria, Filariasis, Schistosomiasis, Typhoid Fever – Specify Date) |
| □ Depression, Other Mental Disorders | □ Other Endocrine Disorders (e.g. Goiter) | □ Asthma |
| □ Trachoma, Other Eye Disorders | □ Cancer or Tumor | □ Allergies (Specify) |
| □ Deafness, Other Ear Disorders | □ Blood Disorders | □ Operations (Specify) |
| □ Nose or Throat Disorders | □ Stomach Pain, Gastritis or Ulcer | |
| □ Tuberculosis | □ Other Abdominal Disorders | |

II. PHYSICAL EXAMINATION. Enter the data called for. Tick (√) appropriate box (□). Under columns A, B, C, tick (√) Yes if Normal; if not, specify findings.

| Weight (kg) | Height (cm) | BMI: | Blood Pressure: | Pulse: | Respiration: |
|---|---|---|---|---|---|

| Vision | Far Vision | | Near Vision | |
|---|---|---|---|---|
| Unaided | OD | OS | OD | OS |
| Aided | OD | OS | OD | OS |

| Ishihara Color Vision: |
|---|
| □ Adequate |
| □ Defective |

| Ear | Hearing by Audiometry | |
|---|---|---|
| Right | □ Adequate | □ Inadequate |
| Left | □ Adequate | □ Inadequate |

| A | Yes | Significant Findings | B | Yes | Significant Findings | C | Yes | Significant Findings |
|---|---|---|---|---|---|---|---|---|
| Skin | | | Neck, Lymph Node, Thyroid | | | Anus – Rectum | | |
| Head, Scalp | | | | | | Genito-Urinary System | | |
| Eyes, external | | | Breast, Axilla | | | Inguinals, Genitals | | |
| Pupils | | | Chest and Lungs | | | Extremities | | |
| Ears | | | Heart | | | Reflexes | | |
| Nose, Sinuses | | | Abdomen | | | Dental (Teeth/ Gums) | | |
| Mouth, Throat | | | Back | | | | | |

III. RESULTS OF ANCILLARY EXAMINATIONS. Tick (√) appropriate box (□).

| | | |
|---|---|---|
| A. Chest x-ray: □ Normal □ With Findings | D. Urinalysis: □ Normal □ With Findings | G. HIV/ AIDS test (optional): □ Reactive □ Nonreactive |
| B. ECG: □ Normal □ With Findings | E. Stool Exam: □ Normal □ With Findings | H. RPR: □ Reactive □ Nonreactive |
| C. CBC: □ Normal □ With Findings | F. HBsAg: □ Reactive □ Nonreactive | I. Blood Type (Specify): |
| Psychological Test: □ Normal □ For Further Evaluation | | |
| Additional Tests (Specify): e.g. Blood Chemistries for 40 y/o and above, Drug Test, Alcohol Test, Liver Function Test, Stool Culture (optional), etc. | | |

IV. SUMMARY. Tick (√) appropriate box (□).

| | | |
|---|---|---|
| Basic Mandatory Medical Examination | □ PASSED | □ WITH SIGNIFICANT FINDINGS |
| Additional Laboratory Tests | □ PASSED | □ WITH SIGNIFICANT FINDINGS |
| Flag/ Host State Medical and Laboratory Requirements | □ PASSED | □ WITH SIGNIFICANT FINDINGS |

V. RECOMMENDATION. Tick (√) appropriate box (□).
The Abovementioned Candidate is:

| | |
|---|---|
| Fit for Sea Duty (Without Restriction) □ | Unfit for Sea Duty □ |
| Fit With Restriction (Indicate restriction: ___________________________________) □ | Temporary Unfit (Reason: __________________________________________) □ |

| Date of PEME (Fitness Date): (dd/mm/yyyy) | Valid Until: (dd/mm/yyyy) |
|---|---|

Name and Signature of Authorized Physician

In Accordance with Medical Examination (Seafarers) Convention 1946 (No.78) and STCW 1978/ 1995 as Amended

***Revised as of March 5, 2008***