MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD

SURNAME:	GIVEN NAME (S):	
DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH CITY COUNTRY	SEX MALE ☐ FEMALE ☐
POSITION ON BOARD: MASTER ☐ DECK OFFICER ☐ ENGINEERING OFFICER ☐ RADIO OPERATOR ☐ RATING ☐	MAILING ADDRESS OF APPLICANT:	

DECLARATION OF THE AUTHORIZED PHYSICIAN

VISION			**COLOR TEST TYPE**	**HEARING**
	WITHOUT GLASSES	**WITH GLASSES**	☐ BOOK ☐ LANTERN	
RIGHT EYE	_____	_____	YELLOW _____ RED _____	RIGHT EAR _____
LEFT EYE	_____	_____	GREEN _____ BLUE _____	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 APPROPIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFCIER / 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.