MEDICAL CERTIFICATE FOR SERVICE AT SEA

CONFIDENTIAL

(in accordance with ILO/IMO/JMS/2011/12 'Guidelines on medical examinations of seafarers)
On board passenger vessels, worldwide trading

Family Name	
Given Names	
Date of birth (day/month/year)	
Home address	
Passport Number	
Nationality	
Department	☐ Deck ☐ Engine ☐ Food handling ☐ Other
Watch keeper	☐ Yes ☐ No
Sex	☐ Female ☐ Male
Number of contracts	☐ First contract on Silversea vessel ☐ Returning crew

A. EXAMINEE'S PERSONAL DECLARATION (Assistance should be offered by medical staff)

Have you ever had any of the following conditions?

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

If any of the above questions were answered 'yes' please give details under 'comments'

Additional questions: yes no

35. Have you ever been signed off as sick or repatriated from a ship? ☐ ☐

36. Have you ever been hospitalized? ☐ ☐

37. Have you ever been declared unfit for sea duty? ☐ ☐

38. Have you ever been restricted or revoked? ☐ ☐

39. Are you aware that you have any medical problems, diseases or illnesses? ☐ ☐

40. Do you feel healthy and fit to perform the duties of your designated position/occupation? ☐ ☐

41. Are you allergic to any medication? ☐ ☐

If so, do you carry an Epi Pen? ☐ ☐

42. Are you taking any non-prescription of prescription medication? ☐ ☐

43. Have you had the influenza vaccine? ☐ ☐

44. Have you had a covid vaccine? ☐ ☐

If so: Name of vaccine_____number of doses____

Dates of administration_____and_____

45. Have you had any surgery in the past six months? If so please list below

46. Do you have any recurrently episodes of diarrhea? If so please comment below

Comments (please add #)

I hereby certify that the personal declaration above is a true statement to the best of my knowledge:

Signature of examinee:_____Date (day/month/year) _____

Witnessed by: (signature):_____Name: (typed or printed) _____

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr._____(the approved medical examiner)

Signature of examinee:_____Date (day/month/year) _____

Witnessed by: (signature):_____Name: (typed or printed) _____

B. MEDICAL EXAMINATION

Sight:

Use of glasses or contact lenses: ☐ yes ☐ no

(If yes, specify which type and for what purpose)

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

	Visual fields	
	Normal	Defective
Right eye		
Left eye		

Colour vision: ☐ not tested ☐ Normal ☐ Doubtful ☐ Defective

Hearing/9:

Pure tone and audiometry (threshold values in dB) Speech & whisper test (metres)

	500 Hz	1000 Hz	2000 Hz	3000 Hz					Normal	Whisper
Right ear								Right ear		
Left ear								Left ear		

Clinical findings:

Height cm	Weight kg
Pulse rate (/ minute)	Rhythm
Blood pressure: Systolic mm Hg	Diastolic mm Hg
Urinalysis: Glucose	Protein Blood

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

Chest X-ray	☐ Not performed	☐ Performed on:	___/___/____ (day/month/year)
Results:			

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

Test	Result		
Haemoglobin "Hb"	g/dl		
Hepatitis B	HBsAg	☐ negative	☐ positive
Stool - Bacteria*1	☐ not performed	☐ negative	☐ positive
Stool - Ova and Parasites*1	☐ not performed	☐ negative	☐ positive
ECG *2			
HIV (+ or -)	☐ negative	☐ positive	
Drug & Alcohol*3	☐ Pass	☐ Fail	☐ Not performed
Additional screening tests at Examiner's discretion (list type of test and result)			
Medical examiner's comments and assessment of fitness, with reasons for any limitations:			

*1 required by the Company for food handlers only
*2 required by the Company for crew members over 40 years of age
*3 required for newly hired seafarers only (before their 1st contract with the Company)

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 examinee medically:

☐ Fit for look-out duty ☐ Not fit for look-out duty

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

☐ Without restrictions ☐ With restrictions Visual aid required: ☐ Yes ☐ No

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

Date medical certificate issued: (day/month/year)_____/_____/_____

Certificate is valid until date (day/month/year):____/_____/_____

Number of medical certificate: _____

Signature of medical examiner: _____

Medical practitioner information (name, license number, address):

- Crew member: please take this original in an envelope with you on board and hand it out to the doctor.

MEDICAL CERTIFICATE FOR SERVICE AT SEA

This Medical Certificate has been issued to meet the requirements of both the International Convention on Standards of Training, Certification and Watch-keeping for Seafarers STCW 1978, as amended (STCW), and the Maritime Labour Convention 2006 (MLC 2006)

1. Authorizing Authority and requirements under which the document is issued

2. Seafarer information	
Family Name:	Given Names
Date of birth (day/month/year)	Sex: ☐ Male ☐ Female
Nationality:	Department:
Crew ID number:	Deck ☐ Engine ☐ Hotel ☐

3. Declaration of the recognized medical practitioner	
I confirm the identification documents were checked at the point of examination: ☐ YES ☐ NO	
Colour vision meets standards in STCW code, section A-I/9? (testing only required every 6 years) * ☐ YES ☐ NO ☐ N/A	Date of last colour vision test (dd/mm/yyyy):
Hearing meets the standards in STCW code, section A-I/9? * ☐ YES ☐ NO ☐ N/A	
Is unaided hearing satisfactory? ☐ YES ☐ NO	
Vision acuity meets the standards in STCW code, section A-I/9? * ☐ YES ☐ NO ☐ N/A	
For Deck and Engine personnel: ☐ Fit for look-out duty ☐ Not fit for look-out duty	
For Hotel Personnel: Hearing and sight are satisfactory and seafarer is fit to work at sea? ☐ Yes ☐ No	
No limitations or restrictions on fitness? ☐ Yes ☐ No (if "No" specify limitations or restrictions):	
Is the seafarer free from any medical condition likely to be aggravated by service at sea or render the seafarer unfit for such service or to endanger the health of other persons onboard? ☐ YES ☐ NO	
I hereby confirm that the medical examination has been carried out in accordance with the ILO/IMO Guidelines on the Medical Examinations of Seafarers. *Official stamp (incl. name) of issuing authority* *Medical examiner signature (print name if not legible)*	*I have been informed of the content of the certificate and of the right to have the case reviewed if limitations are imposed:* *Examinee's signature, signed in the presence of the medical practitioner*
Date of Examination: (dd/mm/yyyy):	*Expiry date of certificate: (dd/mm/yyyy):*

*** N/A for Hotel personnel**