MEDICAL FITNESS CERTIFICATE FOR SEAFARERS

SURNAME: PAPA

GIVEN NAME (S): Diouf

DATE OF BIRTH 11/05/1988

DAY ~~Mercredi~~ 10 MONTH 07 YEAR 2024

PLACE OF BIRTH (City): Bambey

NATIONALITY: Senegalais COUNTRY:

SEX

MALE ☒ FEMALE ☐

POSITION ON BOARD:

MASTER	☐	Other	☐
DECK OFFICER	☐	Please specify:	
ENGINEERING OFFICER	☐		
RADIO OPERATOR	☐		
RATING	☐		
CATERING	☐		

MAILING ADDRESS OF APPLICANT:

ID / DOCUMENT NO:

DECLARATION OF THE AUTHORISED PHYSICIAN

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 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 watch keeping? 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 ☐

Confirming that the applicant has been informed of the content of the certificate and of the right to review in accordance with paragraph 6 of section A-I/9 of the STCW Code.

Signature of Applicant	Name of Applicant	Date

I hereby confirm that the medical examination has been carried out in accordance with the ILO/IMO *Guidelines on the medical examination of seafarers* and the national guidelines of the authorizing administration. On the basis of the examinee's personal declaration, my clinical examination and diagnostic test results recorded on the medical report form, I declare the Examinee:

FIT ☐ UNFIT ☐

For the duty specified above ☐ WITHOUT any / ☐ WITH the following RESTRICTIONS:

NAME AND DEGREE OF PHYSICIAN: _____

ADDRESS: _____

NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: _____

DATE OF ISSUE OF PHYSICIAN'S CERTIFICATE: _____

SIGNATURE OF PHYSICIAN: _____ STAMP OF PHYSICIAN: _____ DATE: _____

DATE OF EXAMINATION: **EXPIRY DATE OF CERTIFICATE:**

This Certificate is issued in compliance with the requirements of both, the STCW Convention, 1978, as amended and the Maritime Labour Convention, 2006

SAIPEM	FORM Group MEDICAL REPORT	Doc. no. FORM_GR-GROUP-HR-HLT-039-E Rev. 03 | Date 17/03/2023 Page 1 of 3 Ref. Doc. CR_GR-GROUP-HR-HLT-011-E

1. PERSONAL ANAMNESIS

Name in full	PAPA DIOUF	Date of Birth	11/05/88 Bambey (DD/MM/YYYY)
Badge No.		Gender	☒ Male ☐ Female ☐ Others
Occupation	RIGGER	Type of Visit	☐ Pre-Employment ☐ Periodical

Please tick box ☐	Yes	No
1. a) Are you at present under medical care or receiving treatment?	☐	☒
b) Are you currently taking medication, prescribed or not, having injection, using an inhaler or have you recently done so, or are you on a special diet?	☐	☒
2. Have you ever suffered from:		
a) Fits, fainting, giddiness or any mental or nervous disorder?	☐	☒
b) Asthma, bronchitis, pneumonia or any other lung disorder?	☐	☒
c) Rheumatism, rheumatic fever, arthritis or any other disorder of joints and muscle?	☐	☒
d) Chest pain, shortness of breath, palpitation, high blood pressure or other disorders of the heart or circulation?	☐	☒
e) Indigestion, peptic ulcer, diarrhea, constipation or any intestinal complaint, hepatitis or other liver disorders, diabetes	☐	☒
f) Kidney, bladder or other genito-urinary disorders?	☐	☒
g) Any injury, operation, physical defect or deformity?	☐	☒
h) Any other illness not mentioned above?	☐	☒
3. a) Have you ever been a patient at a hospital, nursing home or special clinic?	☐	☒
b) Have you ever had any medical investigation carried out?	☐	☒
4. Have you ever had any form of sexually transmitted disease or is there anything about your lifestyle which could expose you to the risk of AIDS or AIDS related condition?	☐	☒
5 a) Have you ever suffered from a mental health condition incl. mental stress, depression, anxiety, or panic attacks?	☐	☒
b) Are you getting enough quality sleep and rest?	☐	☒
c) Have you noticed your mood changes frequently or have you changed your social behavior & interactions with others?	☒	☐
6. Female only: Have you ever had any gynecological or obstetric problems?	☐	☒
7. Have you ever taken drugs other than prescribed by any doctor?	☒	☐
8. a) Non-smoker: Have you smoked in the past?	☒	☐
b) Smokers: How much do you smoke per day?	⟹	
c) What is the average daily consumption of alcohol?	⟹	

Details if "yes"
(including dates and duration and any other relevant information)

Cigarettes ☒ Cigars ☐ Pipes ☐ Number smoked 4

2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father			50	
Mother	40			
Brother / Sister	13			
Brother / Sister	10			
Brother / Sister	17			

I declare to the best of my knowledge and having fully understood the requests related to the above questions which answers are true and complete. I confirm that I have also checked and found correct any answers that are not in my handwriting. I grant permission to take samples of blood, saliva and/or urine or any other sample may be deemed as necessary for the purpose of this examination.
I understand and agree that all fitness and medical results of this examination will be provided only / exclusively to the Company's Medical Department in my best interest and shall be handled by them with strict confidentiality managed and processed in compliance with the GDPR - General Data Protection Regulation 2016/679 and other applicable laws.
I also consent that anonymized data may be used by the Company or disclosed to others for research and statistical purpose. No individual will be identified in this anonymized research

Applicant's Signature
(To be signed in the presence of Medical Examiner)

DATE: 10/07/2024
(DD/MM/YYYY)

3. SUMMARY OF MEDICAL HISTORY OF MR. /MRS. _____

Has the applicant ever had or has now any of the following? If yes, give details in the summary description.

Please, tick box, whether normal or not ☐	Yes	No		Yes	No
1. Ear infection / Sinusitis / Vertigo	☐	☒	8. Endocrine disorder	☐	☒
2. Nose, mouth or throat trouble	☐	☒	9. Hernia / Hydrocele / Piles / Fissures	☐	☒
3. Color blindness / Loss of vision	☐	☒	10. Fistula / Appendicitis / Varicocele	☐	☒
4. Frequent headaches / Fainting	☐	☒	11. Malaria / Tropical Disease	☐	☒
5. Epilepsy / Mental illness	☐	☒	12. Skin disease	☐	☒
6. Hypertension	☐	☒	13. Cancer or tumor	☐	☒
7. Diabetes mellitus	☐	☒	14. Allergy to foods / drugs	☐	☒

Remarks:

4. MEDICAL EXAMINER'S REPORT

If you answer Yes to any of the following questions, please give full details with any ascertainable cause as applicable

Please tick box ☐	Yes	No
8. Measurement & Physical Description		
a) Measurements (to be taken in indoor clothing)	⇨	
b) Please describe general appearance and build:	⇨	
c) Are there any signs of past or present over-indulgence in alcohol, tobacco, or irregular lifestyle	☐	☒
d) Is there any enlargement of lymph nodes or thyroid gland?	☐	☒
e) Are there any scars of material significance?	☐	☒
9. Cardio-vascular System & Blood pressure		
a) Does the heart appear to be enlarged? If "yes", do you consider this to be slight, moderate or marked?	☐	☒
b) Is there any irregularity of rhythm?	☐	☒
c) Is there any abnormality in the arterial pulse?	☐	☒
d) Are there any varicose veins?	☐	☒
e) Blood Pressure: (please record opposite)	⇨	
10. Respiratory System		
a) Is there any abnormality in the shape and development of the chest?	☐	☒
b) Are there any abnormal physical signs in the lungs?	☐	☒
11. Genito / Urinary & Digestive System		
a) Is the urine test abnormal?	☐	☒
b) Is there any abnormal tenderness, enlargement or other palpable abnormality in abdomen?	☐	☒
c) Is a hernia present	☐	☒
d) Is there any dental problem such as caries, recurrent gum and mouth infections, abscess etc.?	☐	☒
12. Nervous System		
a) Is there any sign of disease in the central nervous system?	☐	☒
b) Is there anything to suggest a history of Mental condition?	☐	☒
13. Sense Organs		
a) Is there any affection of the eyes, ears, nose or tongue	☐	☒

Details if "yes"

Height: cm 180 Weight: Kg 65

BMI: Kg/m² Waist Circumference: cm

Systolic / Diastolic: 100/66 Pulse Rate: 54

Vision	Far Vision		Near Vision		Color Vision
Uncorrected	OD 10	OS 10	OD 10	OS 10	Adequate
Corrected	OD	OS	OD	OS	Defective

Remarks:

5. EXAMINATION RESULTS AND REPORT

X-Ray, ECG, Audiogram, Spirometry, Digital Pulse Oximetry, Blood, Urine & Other Laboratory Examination Report

All examination results are to be attached. Please, indicate your remarks in case of abnormal results

1. Chest X-Ray Report (****)

2. ECG Report

3. Audiogram Report

4. Spirometry Report
5. Digital Pulse Oximetry Report 98%

6. Blood Examination Report (Please, attach the results of the following examinations and indicate here below the results):

1) Hemoglobin 13.6	10) MCV (*)	19) HDL Cholesterol
2) RBC	11) MCM (*)	20) LDL Cholesterol
3) WBC	12) MCHC (*)	21) Total Bilirubin
4) Neutrophils	13) Platelet	22) Direct Bilirubin
5) Lymphocytes	14) Reticulocyte (*)	23) AST (SGOT)
6) Monocytes	15) Glycemia = 110	24) ALT (SGPT)
7) Eosinophils	16) Blood Urea	25) Gamma GT
8) Basophils	17) Total Cholesterol	
9) Hematocrit	18) Triglycerides	

7. Urine Examination Report (Physical, Chemical and Microscopy test results: Please attach the results of the following examinations and indicate here below the results). Please indicate abnormalities (if Any):

8. Drugs (***), alcohol screening test Report (***). (Please attach the results of the following examinations and indicate here below the results):

1) Amphetamines	3) Cannabinoid	5) Methamphetamine	7) Alcohol
2) Benzodiazepine	4) Cocaine	6) Opiates	

9. ☐ HIV Test (*)
10. ☐ Tine (Tuberculin test) (*)
11. ☐ HBsAg (**) HBsAb (**)☐ HBcAb (**)☐ HBeAg (**)☐ HBeAb (**)☐ HAVAb(**)☐ HCVAb(**)☐
12. ☐ TPHA (*)
13. ☐ Stool examination (*)
14. ☐ Pharyngeal plug test (*)

(*) Only if specifically required (**) Only to the personnel who have never been vaccinated before or if specifically required

(***) Compulsory on pre-employment medical examination and periodical examination for OFFSHORE and employees involve in Safety Sensitive Positions (SSP). For all other employees depend on circumstances, national and international legal requirements.

(****) Chest X-ray is required on the first examination. Afterwards, the examining physician has the discretion whether to perform it or not, based on physical examination, laboratory results, epidemiological situation and local laws and regulation in the country of origin or assignment.

6. OVERALL SUMMARY, ASSESSMENT AND RECOMMENDATIONS

The present Medical Certificate is valid until: _____

I have examined Mr./Mrs. _____ **and found him/her (tick the box)**

FIT for (offshore/onshore) duty ☐ **UNFIT for duty** ☐ **Pending** ☐

_____
Examining Doctor's Signature
(Stamp, Signature, Name and address of the Physician)

Issuing Entity: _____
Date: _____
(DD/MM/YYYY)