



FORM
Group

MEDICAL FITNESS CERTIFICATE FOR SEAFARERS

Doc. no. FORM_GR-GROUP-HR-HLT-038-E


Rev. 02


Date 17/03/2023

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Ref. Doc. CR_GR-GROUP-HR-HLT-011-E

MEDICAL FITNESS CERTIFICATE FOR SEAFARERS

SURNAME: NDIONE		GIVEN NAME (S): ALY	
DATE OF BIRTH DAY 04 MONTH 01 YEAR 1995		PLACE OF BIRTH (City): Sessene Diobass	SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>
NATIONALITY: sénégalaise COUNTRY:		MAILING ADDRESS OF APPLICANT: ndionestarg5@gmail.com	
POSITION ON BOARD: MASTER <input type="checkbox"/> Other <input type="checkbox"/> DECK OFFICER <input type="checkbox"/> Please specify: ENGINEERING OFFICER <input type="checkbox"/> RADIO OPERATOR <input type="checkbox"/> RATING <input type="checkbox"/> CATERING <input type="checkbox"/>		ID / DOCUMENT NO:	
DECLARATION OF THE AUTHORISED PHYSICIAN			
Confirmation that identification documents were checked at the point of examination: YES <input type="checkbox"/> NO <input type="checkbox"/>			
Hearing meets the standards in STCW Code. Section A-1/9? YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/>			
Unaided hearing satisfactory? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Visual acuity meets standards in STCW Code. Section A-1/9? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Colour vision meets standards in STCW Code. Section A-1/9? (the visual test is required every six years) YES <input type="checkbox"/> NO <input type="checkbox"/>			
Date of the last colour vision test (Day/Month/Year):			
Are glasses or contact lenses necessary to meet the required vision standards? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Able for watch keeping? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Is applicant taking any non-prescription or prescription medications? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NO <input type="checkbox"/>			
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-1/9 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 <input type="checkbox"/> UNFIT <input type="checkbox"/>			
For the duty specified above <input type="checkbox"/> WITHOUT any / <input type="checkbox"/> WITH the following RESTRICTIONS:			
NAME AND DEGREE OF PHYSICIAN: _____			
ADDRESS: _____			
NAME OF PHYSICIAN'S CERTIFYING 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			

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1. PERSONAL ANAMNESIS

Name in full	ALY NDIONE	Date of Birth	04-01-1995 (DD/MM/YYYY)
Badge No.		Gender	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Others
Occupation	RIGGER	Type of Visit	<input type="checkbox"/> Pre-Employment <input type="checkbox"/> Periodical

Please tick box <input type="checkbox"/>		Yes	No	Details if "yes" (including dates and duration and any other relevant information)
1. a)	Are you at present under medical care or receiving treatment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.	Have you ever suffered from:			
a)	Fits, fainting, giddiness or any mental or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Asthma, bronchitis, pneumonia or any other lung disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c)	Rheumatism, rheumatic fever, arthritis or any other disorder of joints and muscle?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
d)	Chest pain, shortness of breath, palpitation, high blood pressure or other disorders of the heart or circulation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
e)	Indigestion, peptic ulcer, diarrhea, constipation or any intestinal complaint, hepatitis or other liver disorders, diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
f)	Kidney, bladder or other genito-urinary disorders?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
g)	Any injury, operation, physical defect or deformity?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
h)	Any other illness not mentioned above?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. a)	Have you ever been a patient at a hospital, nursing home or special clinic?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Have you ever had any medical investigation carried out?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5. a)	Have you ever suffered from a mental health condition incl. mental stress, depression, anxiety, or panic attacks?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Are you getting enough quality sleep and rest?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
c)	Have you noticed your mood changes frequently or have you changed your social behavior & interactions with others?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6.	Female only: Have you ever had any gynecological or obstetric problems?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
7.	Have you ever taken drugs other than prescribed by any doctor?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
8. a)	Non-smoker: Have you smoked in the past?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b)	Smokers: How much do you smoke per day?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c)	What is the average daily consumption of alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Cigarettes ☐ Cigars ☐ Pipes ☐ Number smoked ☐

2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father	53			
Mother	47			
Brother / Sister	27, 25, 22			
Brother / Sister				
Brother / Sister				


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)



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

Ally NDIENE

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	<input type="checkbox"/>	Yes	No		Yes	No
1. Ear infection / Sinusitis / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8. Endocrine disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Nose, mouth or throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9. Hernia / Hydrocele / Piles / Fissures	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Color blindness / Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	10. Fistula / Appendicitis / Varicocele	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Frequent headaches / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	11. Malaria / Tropical Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Epilepsy / Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	12. Skin disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	13. Cancer or tumor	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	14. Allergy to foods / drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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	<input type="checkbox"/>	Yes	No	Details if "yes"	
8. Measurement & Physical Description					
a) Measurements (to be taken in indoor clothing)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Height: cm <i>173</i>	Weight: Kg <i>77</i>
b) Please describe general appearance and build:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	BMI: Kg/m ²	Waist Circumference: cm
c) Are there any signs of past or present over-indulgence in alcohol, tobacco, or irregular lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Is there any enlargement of lymph nodes or thyroid gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Are there any scars of material significance?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
9. Cardio-vascular System & Blood pressure					
a) Does the heart appear to be enlarged?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
If "yes", do you consider this to be slight, moderate or marked?					
b) Is there any irregularity of rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is there any abnormality in the arterial pulse?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Are there any varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
e) Blood Pressure: (please record opposite)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Systolic / Diastolic: <i>113/70</i>	Pulse Rate: <i>62</i>
10. Respiratory System					
a) Is there any abnormality in the shape and development of the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Are there any abnormal physical signs in the lungs?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
11. Genito / Urinary & Digestive System					
a) Is the urine test abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there any abnormal tenderness, enlargement or other palpable abnormality in abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c) Is a hernia present	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d) Is there any dental problem such as caries, recurrent gum and mouth infections, abscess etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
12. Nervous System					
a) Is there any sign of disease in the central nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b) Is there anything to suggest a history of Mental condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
13. Sense Organs					
a) Is there any affection of the eyes, ears, nose or tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Vision				Color Vision	
Uncorrected	OD <i>10</i>	OS <i>10</i>	Near Vision	OD <i>10</i>	OS <i>10</i>
Corrected	OD	OS	OD	OD	OS
				<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Defective	

Remarks:



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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

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

1) Hemoglobin

16.5

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

100

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)

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