SAIPEM	FORM Group MEDICAL FITNESS CERTIFICATE FOR SEAFARERS	Doc. no. FORM_GR-GROUP-HR-HLT-038-E Rev. 02 | Date 17/03/2023 Page 1 of 1 Ref. Doc. CR_GR-GROUP-HR-HLT-011-E

MEDICAL FITNESS CERTIFICATE FOR SEAFARERS

SURNAME: NKOMBO	GIVEN NAME (S): Prince Bertrand
DATE OF BIRTH DAY 02 MONTH 12 YEAR 1982	PLACE OF BIRTH (City): NATIONALITY: Congolese COUNTRY: Congo B SEX MALE ☑ FEMALE ☐
POSITION ON BOARD: MASTER ☑ Other ☐ DECK OFFICER ☐ Please specify: ENGINEERING OFFICER ☐ RADIO OPERATOR ☐ RATING ☐ CATERING ☐	MAILING ADDRESS OF APPLICANT: princebertrand.nk@gmail.com ID / DOCUMENT NO: 14118200173O2

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? (the visual test is required every six years)	YES ☑	NO ☐	
Date of the last colour vision test (Day/Month/Year): 17-07-2025			
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 | Prince Bertrand NKombo (Name of Applicant) | 17/03/25 (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: 18-03-2025

Dr Patrick Correa
Médecine Subaquatique
OEUK/2025/3800
Fann résidence
03 Av des Ambassadeurs
33 824 26 71

SIGNATURE OF PHYSICIAN:

STAMP OF PHYSICIAN: Dr Patrick Correa Médecine Subaquatique OEUK/2025/3800 Fann résidence 03 Av des Ambassadeurs 33 824 26 71

DATE: 18-03-2025

DATE OF EXAMINATION: 17-03-2025 **EXPIRY DATE OF CERTIFICATE:** 17-03-2026

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		Date of Birth		Blood group	Rh
Badge No.		Gender	☐ Male	☐ Female	☐ Others
Occupation		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 or are you suffering 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 genitourinary 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 due to sickness?	☐	☑
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 HIV or HIV related condition?	☐	☑
5 a) Have you ever suffered from a mental health condition incl. mental stress, depression, anxiety, or panic attacks?	☐	☑
b) 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)

For current smoker:
Cigarettes ☐ Cigars ☐ Pipes ☐ Number smoked ☐

2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father			82 anni	
Mother	71			
Brother / Sister	51			
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: 17/03/25
(DD/MM/YYYY)

3. SUMMARY OF MEDICAL HISTORY OF ____________________

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: Suivi. pour HTA TTé. stable. à 140 Systole → + Ex [illegible].

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	Details if "yes"
1. Measurement & Physical Description			
a) Measurements (to be taken in indoor clothing)	⇨		Height: 173 cm Weight: 88 Kg
b) Please describe general appearance and build:	⇨		BMI: Kg/m² Waist Circumference: cm
c) Are there any signs of past or present overindulgence 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?	☐	☑	
2. 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)	⇨		Systolic / Diastolic: 149/10 Pulse Rate: 72
3. 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?	☐	☑	
4. Genito / Urinary & Digestive System			
a) Is there any abnormal tenderness, enlargement or other palpable abnormality in abdomen?	☐	☑	
b) Is a hernia present	☐	☑	
c) Is there any dental problem such as caries, recurrent gum and mouth infections, abscess etc.?	☐	☑	
5. 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?	☐	☑	
6. Sense Organs			
a) Is there any affection of the eyes, ears, nose, or tongue	☐	☑	

Vision	Far Vision		Near Vision		Color Vision
Uncorrected	OD 7	OS 8	OD 10	OS 10	(Adequate)
Corrected	OD	OS	OD	OS	Defective

Remarks:

5. EXAMINATION RESULTS AND REPORT

X-Ray, Resting ECG, Exercise ECG, Audiogram, Spirometry, Blood, Urine & Other Laboratory Examination Reports

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

1. Chest X-Ray Report (****)
2. Resting ECG Report RAS.
3. Exercise ECG Stress Test Report (*****)
4. Audiogram Report
5. Spirometry Report
6. Blood Examination Report (Please, attach the results of the following examinations and indicate here below the results):

Hemoglobin	Basophils	Glycemia	Triglycerides
RBC	Hematocrit	HbA1c	Total Bilirubin
WBC	MCV (*)	Blood Urea Nitrogen	Direct Bilirubin
Neutrophils	MCM (*)	Creatinine	AST (SGOT) 5 UI/l
Lymphocytes	MCHC (*)	Total Cholesterol 2,57 g/l	ALT (SGPT)
Monocytes	Platelet	HDL Cholesterol	Gamma GT
Eosinophils	Reticulocyte (*)	LDL Cholesterol 1,79 g/l	

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 2) Benzodiazepine 3) Cannabinoid 4) Cocaine 5) Methamphetamine 6) Opiates 7) Alcohol
9. ☐ HIV Test (*)
10. ☐ Tine (Tuberculin test) (*)
11. ☐ HBsAg (**) HBsAb (**) ☐ HBcAb (**) ☐ HAVAb(**) ☐ HCVAb ☐
12. ☐ TPHA or VDRL (*)
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.
(*****) Exercise ECG Stress Test following Bruce Protocol Stage III is required for all employees of 45 years and above on the date of examination on international and/or offshore assignment. Local employee may be subject to local laws and regulations.

6. OVERALL SUMMARY, ASSESSMENT AND RECOMMENDATIONS

This Health Certificate is valid until: 17-03-2026 (DD/MM/YYYY)

I have examined NKOMBO Prince B **and found him/her (tick the box)**

☒ Fit
☐ Fit with recommendations and/or restrictions
☐ Unfit

☒ Offshore ☒ Onshore
☐ permanent ☐ temporary for months .....
☐ permanent ☐ temporary for months .....

Specify recommendations and/or restrictions, if any
.....

Dr Patrick Correa
Médecine Subaquatique
OEUK/2025/3800
Fann résidence
03 Av des Ambassadeurs
33 824 26 71

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

Issuing Entity: _____

Date (DD/MM/YYYY) 18-03-2025

Scanned copies of both, "Medical Fitness Certificate" Form (FORM_GR-GROUP-HR-HLT-040-E) and Medical Report" Form (Doc. no. FORM_GR-GROUP-HR-HLT-039-E) together with the results of the Diagnostic and Laboratory results shall be sent confidentially to Saipem Overseas Health System (email Address: MEDES.Health@saipem.com). For any query related to this medical, please contact Saipem Health on the same email address.