

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: DIARA		GIVEN NAME (S): Babacan	
DATE OF BIRTH DAY 25 MONTH 08 YEAR 1988		PLACE OF BIRTH (City): NATIONALITY: Senegalese COUNTRY: Senegal	SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>
POSITION ON BOARD: MASTER <input type="checkbox"/> Other <input checked="" type="checkbox"/> DECK OFFICER <input type="checkbox"/> Please specify: IT Systems ENGINEERING OFFICER <input type="checkbox"/> Administrative RADIO OPERATOR <input type="checkbox"/> RATING <input type="checkbox"/> CATERING <input type="checkbox"/>		MAILING ADDRESS OF APPLICANT: babacan.diana-guest@saipem.com ID / DOCUMENT NO: 1755 1988 03164	
DECLARATION OF THE AUTHORISED PHYSICIAN			
Confirmation that identification documents were checked at the point of examination: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Hearing meets the standards in STCW Code. Section A-1/9? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/>			
Unaided hearing satisfactory? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Visual acuity meets standards in STCW Code. Section A-1/9? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Colour vision meets standards in STCW Code. Section A-1/9? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (the visual test is required every six years)			
Date of the last colour vision test (Day/Month/Year): 21-11-2024			
Are glasses or contact lenses necessary to meet the required vision standards? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Able for watch keeping? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Is applicant taking any non-prescription or prescription medications? YES <input type="checkbox"/> NO <input checked="" 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 checked="" 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: Babacan DIARA		Name of Applicant: Babacan DIARA	
		Date: 21/11/2024	
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 checked="" type="checkbox"/> UNFIT <input type="checkbox"/>			
For the duty specified above <input type="checkbox"/> WITHOUT any / <input checked="" type="checkbox"/> WITH the following RESTRICTIONS: Not wear. corrected Glasses			
NAME AND DEGREE OF PHYSICIAN:		Dr Patrick CORREA	
ADDRESS:		3 Av. des Ambassadeurs Fann	
NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY:		Résidence Dakar - Sénégal	
DATE OF ISSUE OF PHYSICIAN'S CERTIFICATE:		MEDECINE SUBAQUATIQUE / HYPERBARE	
SIGNATURE OF PHYSICIAN: [Signature]		Tél : 33 824 26 71	
		03-12-2024	
DATE OF EXAMINATION: 21-11-2024		EXPIRY DATE OF CERTIFICATE: 21-11-2025	

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	Babacan DIARA	Date of Birth	25/08/1988 (DD/MM/YYYY)
Badge No.		Gender	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Others
Occupation	IT Systems Administrator	Type of Visit	<input type="checkbox"/> Pre-Employment <input checked="" 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 type="checkbox"/>	<input checked="" 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 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"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes <input type="checkbox"/> Number smoked <input type="checkbox"/>		
c)	What is the average daily consumption of alcohol?	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes <input type="checkbox"/> Number smoked <input type="checkbox"/>		


2. FAMILY MEDICAL ANAMNESIS

	If living, age	State of health	If dead, age at death	Cause of death
Father			65	natural
Mother	68			
Brother / Sister	33	Healthy		
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: 21/11/2024
 (DD/MM/YYYY)

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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	<input type="checkbox"/>	Yes	No		Yes	No
1. Ear infection / Sinusitis / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>
2. Nose, mouth or throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Hernia / Hydrocele / Piles / Fissures	<input type="checkbox"/>	<input type="checkbox"/>
3. Color blindness / Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Fistula / Appendicitis / Varicocele	<input type="checkbox"/>	<input type="checkbox"/>
4. Frequent headaches / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Malaria / Tropical Disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Epilepsy / Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Skin disease	<input type="checkbox"/>	<input type="checkbox"/>
6. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Cancer or tumor	<input type="checkbox"/>	<input type="checkbox"/>
7. Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Allergy to foods / drugs	<input type="checkbox"/>	<input 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 type="checkbox"/>	Height: <u>187</u> cm	Weight: <u>75</u> Kg
b) Please describe general appearance and build:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input 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 type="checkbox"/>	<input checked="" type="checkbox"/>		
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 Uncorrected OD _____ OS _____ Corrected OD <u>10</u> OS <u>09</u>		Near Vision OD _____ OS _____ OD <u>10</u> OS <u>10</u>		Color Vision Adequate <u>10</u> 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 (****) *RAS*

2. ECG Report *RAS*

3. Audiogram Report *RAS*

4. Spirometry Report

5. Digital Pulse Oximetry Report

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

- | | | |
|----------------|------------------------------|----------------------|
| 1) Hemoglobin | 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 <i>0,91 g/l</i> | 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): *RAS*

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 (**) ☐ 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: *31-11-2025*

I have examined Mr./Mrs. *DIARA Babacan* 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: *03-12-2024. Dr CORREA*

Date: *03-12-2024*
(DD/MM/YYYY)

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