



Medical examination Shipping crew

Contact the medical examiner for more information about this form.

More information

+31(0) 88 489 00 00 | www.ilent.nl

1 Details seafarer

- 1.1 Surname and Gender Male Female
- 1.2 First names in full
- 1.3 Date of birth and place of birth
- 1.4 Nationality
- 1.5 Address
- 1.6 Postcode and city
- 1.7 Telephonenumber(s)
- 1.8 Number seaman's book and country of issue
- 1.9 Number of ID or passport

2 Details of family doctor/G.P.

- 2.1 Name
- 2.2 Address

3 Details work/education

- 3.1 Name ship owner / nautical college
- 3.2 Type of ship
- 3.3 Duties on board the ship
- 3.4 Sailing area

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Details of previous examinations

- 4.1 Have you ever been declared unfit for duty? Yes No
- 4.2 Have you ever been declared fit with restrictions? Yes No
- 4.3 Have you ever had a medical exemption? Yes No
- 4.4 Date of the last medical examination | _____
- 4.5 Details _____

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Details present examination

- 5.1 Your examination concerns
- Seafarer with look-out or watch duties on the bridge
- Seafarer with watch duties in the engine room
- Seafarer without look-out or watch duties, but with safety and/or security duties
- Seafarer without safety and/or security duties

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Medical questions

- 6.1 Do you experience any limitations in the performance of your duties? Yes No
- 6.2 Have you ever been repatriated due to illness? Yes No
- 6.3 Have you ever had an accident? Yes No
- 6.4 Have you ever had surgery? Yes No
- 6.5 Can you use both hands unrestricted in range of motion and sensibility? Yes No
- 6.6 Have you suffered from any occupational disease? Yes No
- 6.7 Are you allergic to any substance? Yes No
- 6.8 Are you night blind? Yes No
- 6.9 Do you wear glasses or contact lenses? Yes No
- 6.10 Is your colour vision normal? Yes No
- 6.11 Have you had eye surgery or laser treatment? Yes No
- 6.12 Do you use a hearing-aid? Yes No
- 6.13 Do you take any medication? If so, which? Yes No
- 6.14 Do you drink alcohol? If so, how many units per week? Yes No | _____ a week
- 6.15 Do you smoke? If so, how many per day? Yes No | _____ a day
- 6.16 Did you use illegal drugs during the past 5 years? Yes No
- 6.17 Are you pregnant? Expected date of delivery? Yes No N.a. | _____
- 6.18 Do you have painful or irregular periods? yes No N.a.
- 6.19 When was your last visit to the dentist? | _____
- 6.20 Can you turn a rescue raft? (STCW-training) | _____
- 6.21 Are you able to wear a breathing apparatus? (STCW-training) | _____

6.22 Details

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Physical complaints

7.1 Do or did you suffer from any of the following?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contagious diseases, tropical diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trombosis or embolism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy, seizures or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous strain, depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fear of heights / open spaces / claustrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insomnia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep-walking, bed-wetting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin diseases, eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Venereal diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inguinal hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Varicose veins, haemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache, dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Syncope, fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low vision or blurred vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poor hearing or ringing in the ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Coughing, shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma, bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain, palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen feet, especially in the evening	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach-ache, nausea, low appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal pain, cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Black or discoloured stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Strain or pain during urinating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in the back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Painful arms, legs or joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractures, dislocations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seasickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7.2 Details

8 Signature

The undersigned is aware of the fact that due to false or inaccurate completion of this medical history the medical examination may be considered invalid. The undersigned therefore certifies that the personal declaration above is a true statement to the best of his or her knowledge.

8.1 Place and date	<hr/>
8.2 Signature	<hr/>

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9 Details examination and medical examiner

- 9.1 Date of examination _____
- 9.2 Name medical examiner _____

10 Physical examination

- 10.1 Length and body weight _____
- 10.2 BMI _____
- 10.3 Waist circumference (optional) _____
- 10.4 Pulse and blood pressure _____
- 10.5 General physical appearance _____
- 10.6 Mental state _____
- 10.7 Skin _____
- 10.8 Lymph nodes _____
- 10.9 Neck / thyroid _____
- 10.10 Mouth / throat / nose _____
- 10.11 Dental status _____
- 10.12 Speech _____
- 10.13 Heart _____
- 10.14 Lungs _____
- 10.15 Abdomen _____
- 10.16 Genitals, groins _____
- 10.17 Upper extremities _____
- 10.18 Lower extremities _____
- 10.19 Spine _____
- 10.20 Motor system _____
- 10.21 Co-ordination _____
- 10.22 Reflexes _____

11 Fitness and physical abilities

- 11.1 Climb up and down vertical ladders Sufficient Inadequate _____
- 11.2 Step over coamings (60cm) Sufficient Inadequate _____
- 11.3 Grasp, lift, manipulations Sufficient Inadequate _____
- 11.4 Reach above shoulder height Sufficient Inadequate _____
- 11.5 Stoop, crouch, kneel and crew Sufficient Inadequate _____
- 11.6 Stand and walk a watch for extended periods Sufficient Inadequate _____
- 11.7 Fit through a restricted opening of 60x60 cm Sufficient Inadequate _____

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12 Vision / eyes

12.1	Visual acuity, unaided	OD	OS	ODS
12.2	Visual acuity, aided	OD	OS	ODS
12.3	Near vision, aided			ODS
12.4	Reading a computer at a distance of 70 cm			ODS
12.5	Visual fields	OD	OS	
12.6	External inspection	OD	OS	
12.7	Eye movements	OD	OS	
12.8	Pupillary light reflex	OD	OS	
12.9	Signs of double vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12.10	Spare glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Colour vision

12.11	Ishihara 2 or more mistakes	<input type="checkbox"/> No	<input type="checkbox"/> Yes (detailed examination required)	
12.12	Specialist colour test	<input type="checkbox"/> Sufficient	<input type="checkbox"/> Defective	
12.13	Specialist colour test used, plus results			

More detailed examination required

12.14	Night-blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12.15	Ophthalmoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

13 Hearing/ ears

13.1	Conversational speech	AD	m	AS	m
13.2	Tone-audiometric loss 500 Hz.	AD	dB	AS	dB
13.3	Tone-audiometric loss 1000 Hz.	AD	dB	AS	dB
13.4	Tone-audiometric loss 2000 Hz.	AD	dB	AS	dB
13.5	Tone-audiometric loss 3000 Hz.	AD	dB	AS	dB
13.6	Tone-audiometric loss average	AD	dB	AS	dB
13.7	Otoscopy	AD			
		AS			

14 Diagnostic tests

14.1	Does the candidate come from an area with a high prevalence of tuberculosis?	<input type="checkbox"/> Yes (Examination on tuberculosis indicated)	
		<input type="checkbox"/> No	
14.2	Chest X-ray / Mantoux date, plus results		
14.3	Urine:		
	Protein		
	Glucose		
	Blood		

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15 Additional diagnostic tests

15.1 Remarks

16 Specialist report

16.1 Remarks

17 Family history

17.1 Remarks

18 Consultation with attending physician

18.1 Remarks

19 Comments, notes

19.1 Remarks

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20 Validation exemptions

20.1 The exemptions given by the medical advisor are valid until?

Exemption with regard to general medical fitness: _____

Exemption with regard to the visual system: _____

Exemption with regard to the auditory system: _____

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Conclusion seafarer's examination

21.1

Complies to the medical standards of	Look-out or watch duties on the bridge			Watch duties in the engine room			Without look-out or watch duties, but with safety and/or security duties			Without look-out, watch, safety or security duties		
	Yes	Exemption*	No	Yes	Exemption*	No	Yes	Exemption*	No	Yes	Exemption*	No
Medical fitness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONCLUSION	<input type="checkbox"/> Fit for duty *		<input type="checkbox"/> Unfit **	<input type="checkbox"/> Fit for duty *		<input type="checkbox"/> Unfit **	<input type="checkbox"/> Fit for duty *		<input type="checkbox"/> Unfit **	<input type="checkbox"/> Fit for duty *		<input type="checkbox"/> Unfit **

* The expiry date of the Seafarer medical certificate may never exceed the expiry date on the exemption.

** A candidate is unfit if "No" is ticked once, unless the candidate holds a valid exemption.

21.2 Restrictions to area of validity

21.3 Restrictions to period of validity
