

Condition	YES	NO	Condition	YES	NO
1 Eye/vision problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18 Sleep problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2 High blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19 Do you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3 Heart/vascular disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20 Operation/surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4 Heart surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21 Epilepsy/seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5 Varicose veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22 Dizziness/fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6 Asthma/bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23 Loss of consciousness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7 Blood disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24 Psychiatric problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25 Depression	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9 Thyroid problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26 Attempted suicide	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10 Digestive disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27 Loss of memory	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11 Kidney problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28 Balance problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12 Skin problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29 Severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13 Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30 Ear/nose/throat problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14 Infectious/contagious diseases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31 Restricted mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15 Hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32 Back problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16 Genital disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33 Amputation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17 Pregnancy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	34 Fractures/dislocations	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If any of the above questions were answered "yes", please give details.

**Additional questions**

	YES	NO
35 Have you ever been signed off as sick or repatriated from a ship?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
36 Have you ever been hospitalised?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
37 Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
38 Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
39 Are you aware that you have any medical problems, diseases or illnesses?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
40 Do you feel healthy and fit to perform the duties of your designated position/occupation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
41 Are you allergic to any medications?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments:

**Fit For Duty On Board Ship**

42 Are you taking any non-prescription or prescription medications?  YES  NO

If yes, please list the medications taken and the purpose(s) and dosage(s)

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. Paritosh Chakraborty (approved medical practioner) I also certify that my history contained above is true and any false statement will disqualify me from my employment, benefits and claims.

*Sawad*

Signature of Seafarer

**MEDICAL EXAMINATION**

Weight **70kg** Height (cm) **180cm** BM **21** Blood Pressure: Systolic **110 mmHg** Diastolic **70 mmHg** PULSE: **72/m**

Ear	Hearing by Audiometry	
Right	<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
Left	<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate

Audiometry			
500	1000	2000	3000
N.A			

Hearing by Whisper Test	
<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate

Hearing meets the standards as laid down in STCW Code Section A-1/9? YES  NO

Visual acuity meets the standards set down in STCW Code  
 Colour vision as per STCW CODE Section 4.1.1

Date of last colour vision test: Date (day/month/year) 19 DEC 2024

	Normal	Abnormal		
Head	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input checked="" type="checkbox"/>
Sinuses, nose, throat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Vascular (inc. pedal pulses)	<input checked="" type="checkbox"/>
Mouth/teeth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	<input checked="" type="checkbox"/>
Ears (general)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hernia	<input checked="" type="checkbox"/>
Tympanic membrane	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Anus (not rectal exam)	<input checked="" type="checkbox"/>
Eyes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	G-U system	<input checked="" type="checkbox"/>
Ophthalmoscopy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Upper and lower extremities	<input checked="" type="checkbox"/>
Pupils	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Spine (C/S, T/S and L/S)	<input checked="" type="checkbox"/>
Eye movement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neurologic (full brief)	<input checked="" type="checkbox"/>
Lungs and chest	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input checked="" type="checkbox"/>
Breast examination <u>N.A</u>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance	<input checked="" type="checkbox"/>
Heart	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Skin	<input checked="" type="checkbox"/>

RESULTS OF ANCILLARY EXAMINATIONS

Chest X-Ray	<u>NORMAL</u>	BIO CHEMICAL (LIVER FUNCTION TEST)	Marijuana	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative
ECG	<u>NAD</u>	BILIRUBIN	Alcohol Test	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative
BLOOD R/E		SGPT	URINE R/E	<u>NAD</u>
DC (differential count)	<u>NAD</u>	SGOT	OTHERS	
HAEMOGLOBIN (HGB)	<u>15.0</u>	DRUG AND ALCOHOL TEST	HBsAg	<input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Nonreactive

Hereby I declare that I am in knowledge of the contents of the Physical examinations:

Signature of Seafarer: Sayed Name of Seafarer: JAWAD ZAHURI Date: 19 DEC 2024

Assessment of fitness for service at sea:

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically:

Fit for lookout duties  Not fit for lookout duties

	Deck service	Engine service	Catering service	Other services
Fit	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unfit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Without restrictions  With restrictions

Is the Seafarer free from any medical conditions likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board?

Yes  No

Describe restrictions (e.g., specific position, type of ship, trade area): No Restrictions

Action taken by medical examiner (e.g., referral):

Fitness Date: 19 DEC 2024 Valid Until: 18 DEC 2026

Name and Signature of Authorized Physician: Dr. Chakraborty