



HAQUE & SONS LTD.

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Accredited By BMDC
Accreditation No A16713

PATIENT CONTROL NUMBER
<NO>

MEDICAL EXAMINATION CERTIFICATE

SURNAME MAHMUD	FIRST NAME MD	MIDDLE NAME KAWSAR
PLACE AND DATE OF BIRTH NATORE 8-Jul-1998	PASSPORT NUMBER A03427775	SEAMAN'S BOOK NUMBER T32464
NATIONALITY : BANGLADESHI SEX : <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		
VESSEL TYPE : CHEM. TANKER TRADING AREA : WORLD WIDE		
PERMANENT HOME ADDRESS : C/O: MD. HABIBUR RAHAMAN, HOUSE NO.: H299, VILL. HUTDOL, P.O.: YASINPUR, PS. BAGATIPARA, DIST. NATORE, BANGLADESH.		CONTACT NUMBER : 01746-336060 (SELF)/017
RANK :		AB

Have you ever had any of the following conditions?

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

Question	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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.

Handwritten signature

Signature of Seafarer

MEDICAL EXAMINATION

Weight **69 kg** Height (cm) **165 cm** BM **25** Blood Pressure: Systolic **120 mmHg** Diastolic **80 mmHg** PULSE: **72 bpm**

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 checked="" 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				Visual fields	
	Unaided		Aided		Normal	Defective
	Right eye	Left eye	Right eye	Left eye		
Distant	6/6	6/6			<input checked="" type="checkbox"/>	
Near	NS	NS			<input checked="" type="checkbox"/>	

Visual acuity meets the standard laid down in STCW Code Section A-1/9
 Colour vision as per STCW CODE Section A-1/9: Normal Doubtful Defective

Date of last colour vision test: Date (day/month/year) **29 OCT 2024**

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

N.A

RESULTS OF ANCILLARY EXAMINATIONS

Chest X-Ray	NORMAL	BIO CHEMICAL (LIVER FUNCTION TEST)	Marijuana	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative
ECG	NAD	BILIRUBIN	Alcohol Test	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative
BLOOD R/E		SGPT	URINE R/E	NAD
DC(differential count)	NAD	SGOT	OTHERS	
HAEMOGLOBIN (HGB)	14.2	DRUG AND ALCOHOL TEST		
ESR (WESTERGREN)	13.0	Morphine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	HBsAg
WBC	7800	Amphetamine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	HIV / AIDS Test
BLOOD GLUCOSE LEVEL		Phencyclidine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	VDRL
RANDOM	102	Barbiturates	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Blood Type
HBA1C	4.0	Cocaine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Psychological Exam
				Others (KUB Ultrasound)

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

Signature of Seafarer: MD KAWSAR MAHMUD Name of Seafarer: MD KAWSAR MAHMUD Date: 29 OCT 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 checked="" type="checkbox"/>	<input 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: **29 OCT 2024** Valid Until: **28 OCT 2026**