



MINISTRY OF ECONOMIC DEVELOPMENT, TRANSPORT & TRADE
Male' Republic of Maldives

**MEDICAL FITNESS STANDARDS CERTIFICATE
FOR SEAFARERS**

This certificate is issued in accordance with the provision of regulation 1/9 of the 1978 STCW Convention, as amended and the standard A-1/2 of the MLC, 2006, as amended, and certifies that seafarers are fit for sea service.

Name:	Address:	Passport No: <input style="width: 80%;" type="text"/>
		ID Number: <input style="width: 80%;" type="text"/>
Date of Birth Day Month Year ____ / ____ / ____	Nationality	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>

	Yes	No
<i>Confirm that identification documents were checked at the point of examination</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hearing meets the standards?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Unaided Hearing Satisfactory?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Visual acuity meets standards</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Colour vision meets standards</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Date of last colour vision test (Day/Month/year) ____/____/____</i>		
<i>Fit for lookout duties?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Limitation or restriction on fitness? If "yes" specify limitation or restrictions?</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
<i>Are the seafarers 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 another person on board?</i>	<input type="checkbox"/>	<input type="checkbox"/>

<i>I hereby confirm that I have been informed about the content of this certificate and of the right to review in accordance with paragraph 6 of Section A-1/9.</i>	<i>Seafarers Signature</i>
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<i>Date of Issue</i>	
<i>Date of Expiry</i>	
<i>Name of the recognized medical practitioner</i>	

<i>Signature and Stamp of the recognized medical practitioner</i>

1. *The original certificate must be available while serving on board ship*
2. *In case of loss of this certificate the holder should notify port and the Ministry*
3. *The authenticity of this certificate can be verified by contacting the Ministry*



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MEDICAL TEST (VALID 2 YRS) * DECK/ENGINE SEAFARERS
MEDICAL FITNESS CERTIFICATE

(Issued in compliance with the requirements of the ILO convention 73, 147
and STCW 78 as amended)

Name: _____ (In block letters as in Passport)

First: _____ Middle: _____ Last: _____

Date of Birth: (DD/MM/YYYY) _____

Sex: Male: Female:

Home Address: _____

Passport Number: _____

Department: (Deck/Engine/Other) _____

Type of Ship/Trading area: _____

Purpose of sight test: _____

Date: _____

Signature of Applicant: _____

RESULT OF MEDICAL EXAMINATIONS

To Be Filled by Approved Medical Practitioner / Examiner

I certify that the above - named sea farer was examined by me with the following results.

APPLICANT'S DECLARATION:

Have you ever had any of the following conditions?

	YES	NO
1. Eye/Vision problem		
2. High Blood pressure		
3. Heart/Vascular disease		
4. Heart Surgery		
5. Varicose veins/piles 3 of 7		
6. Asthma/Bronchitis		
7. Blood disorder		
8. Diabetes		
9. Thyroid problem		
10. Digestive disorder		
11. Kidney problem		
12. Skin Problem		
13. Allergies		
14. Infectious/contagious diseases		
15. Hernia		
16. Genital disorders		
17. Pregnancy		
18. Sleep problem		
19. Do you smoke, use alcohol or drugs?		
20. Operation/Surgery		
21. Epilepsy/Seizers		
22. Dizziness/Fainting		
23. Loss of consciousness		
24. Psychiatric problems		
25. Depression		
26. Attempted suicide		
27. Loss of memory		
28. Balance problem		
29. Severe headache		
30. Ear (Hearing, tinnitus)/Nose/Throat/problem		
31. Restricted mobility		
32. Back or joint problem		
33. Amputation		
34. Fractures/Dislocations		

If you answered "YES" to any of the above questions, please give details
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Additional	Yes	No
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- 35. Have you ever been signed off as sick or repatriated from a ship?
- 36. Have you ever been hospitalized?
- 37. Have you ever been declared unfit for sea duty?
- 38. Has your medical certificate even been restricted or revoked?
- 39. Are you aware that you have any medical problems, diseases or illnesses?
- 40. Do you feel healthy and fit to perform the duties of your designated position/occupation?
- 41. Are you allergic to any medication?

Comments:

Additional questions	Yes	No
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- 42. Are you taking any non-prescription or prescription medication?

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

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

Signature of examinee: _____ Date (day/month/year):/...../.....

Witnessed by (signature): _____ Name (typed or printed): _____

I hereby authorize the release of all my previous medical records from any health professionals,
health institutions and public authorities to Dr. _____

(the approved medical practitioner) Signature of examinee: _____ Date (day /month/year):/...../.....

Witnessed by (signature): _____ Name (typed or printed): _____

Date and contract details for previous medical examination (if known): _____

Chest X-ray

Not performed Performed on (Day/Month/Year) :...../...../.....

Results:
Other diagnostic test(s) and result(s):

Test Result:

Medical practitioner's comments and assessment of fitness, with reasons for any limitations:

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 look- out duty Not fit for look-out duty

	Deck service	Engine service	Catering service	other services
Fit	<input 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	<input type="checkbox"/> with restrictions	<input type="checkbox"/> Visual aid required	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Describe restrictions (e.g. Specific position, type of ship, trade area)

Medical certificate's date of expiration (day /month/year):...../...../.....

Date medical certificate issued (day/month/year)/...../.....

Number of medical certificate: _____

Signature of medical practitioner: _____

Medical practitioner information (name, license number, address):

Maximum validity of this certificate should not be more than 02 yrs