



MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD REPUBLIC OF PANAMA

SURNAME:	GIVEN NAME (S):		
DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH CITY COUNTRY	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
POSITION ON BOARD: MASTER <input type="checkbox"/> DECK OFFICER <input type="checkbox"/> ENGINEERING OFFICER <input type="checkbox"/> RADIO OPERATOR <input type="checkbox"/> RATING <input type="checkbox"/>	MAILING ADDRESS OF APPLICANT:		

DECLARATION OF THE AUTHORIZED PHYSICIAN

	VISION		COLOR TEST TYPE	HEARING
	WITHOUT GLASSES	WITH GLASSES	<input type="checkbox"/> BOOK <input type="checkbox"/> LANTERN YELLOW _____ RED _____ GREEN _____ BLUE _____	RIGHT EAR _____ LEFT EAR _____
RIGHT EYE	_____	_____		
LEFT EYE	_____	_____		

Confirmation that identification documents were checked at the point of examination: YES NO

Hearing meets the standards in STCW Code, Section A-1/9? YES NO NOT APLICABLE

Unaided hearing satisfactory? YES NO

Visual acuity meets standards in STCW Code, Section A-1/9? YES NO

Colour vision meets standards in STCW Code, Section A-1/9? YES NO
(the visual test it is required every six years)

Date of the last colour vision test: (Day/Month/Year) ____ / ____ / ____ .

Are glasses or contact lenses necessary to meet the required vision standards? YES NO

Able for watchkeeping? YES NO

Is applicant taking any non-prescription or prescription medications? YES NO

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 NO

Hereby I declare that I am in knowledge of the contents of the Physical Examination.

Signature of Applicant

Name of Applicant

Date

CIRCLE APPROPRIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFICER / ENGINEERING OFFICER / RADIO OPERATOR / RATING) (WITHOUT ANY / WITH THE FOLLOWING) RESTRICTIONS:

NAME AND DEGREE OF PHYSICIAN: _____

ADDRESS: _____

NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: _____

DATE OF ISSUE PHYSICIAN'S CERTIFICATE: _____

SIGNATURE OF PHYSICIAN: _____ | STAMP OF PHYSICIAN: _____ | DATE: _____

EXPIRY DATE OF CERTIFICATE: _____

This certificate is issued by the Panama Maritime Authority in compliance with the requirements of the STCW Convention, 1978, as amended and the Maritime Labour Convention, 2006.



FORMAT FOR RECORDING MEDICAL EXAMINATIONS OF SEAFARERS

Name (last, first, middle): _____

Date of birth (day/month/year): ____/____/____ Sex: Male Female

Home address: _____

Passport No./discharge book No: _____

Department: (deck/engine/radio/food handling/other): _____

Routine and emergency duties: _____

Type of ship (container, tanker, passenger, fishing): _____

Trade area (e.g., coastal, tropical, worldwide): _____

EXAMINEE'S PERSONAL DECLARATION (ASSISTANCE SHOULD BE OFFERED BY MEDICAL STAFF)

Have you ever had any of the following conditions?

	Condition	YES	NO		Condition	YES	NO
1.	Eye / vision problem	<input type="checkbox"/>	<input type="checkbox"/>	19.	Do you smoke, use alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2.	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	20.	Operation/surgery	<input type="checkbox"/>	<input type="checkbox"/>
3.	Heart/vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	21.	Epilepsy/ seizures	<input type="checkbox"/>	<input type="checkbox"/>
4.	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	22.	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
5.	Varicose veins/piles	<input type="checkbox"/>	<input type="checkbox"/>	23.	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
6.	Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	24.	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
7.	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	25.	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
8.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	26.	Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
9.	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	27.	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
10.	Digestive disorder	<input type="checkbox"/>	<input type="checkbox"/>	28.	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>
11.	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	29.	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
12.	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	30.	Ear (hearing/ tinnitus) nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>
13.	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	31.	Restricted mobility	<input type="checkbox"/>	<input type="checkbox"/>
14.	Infectious/contagious diseases	<input type="checkbox"/>	<input type="checkbox"/>	32.	Back or joint problems	<input type="checkbox"/>	<input type="checkbox"/>
15.	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	33.	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
16.	Genital disorders	<input type="checkbox"/>	<input type="checkbox"/>	34.	Fractures/dislocation	<input type="checkbox"/>	<input type="checkbox"/>
17.	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
18.	Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input 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 type="checkbox"/>
36.	Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
37.	Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input type="checkbox"/>
38.	Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Are you aware that you have any medical problems, diseases or illness?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Do you feel healthy and fit to perform the duties of your designed position/occupation?	<input type="checkbox"/>	<input type="checkbox"/>
41.	Are you allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

		SI	NO
42.	Are you taking any non-prescription or prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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 contact details for previous medical examination (if known): _____

MEDICAL EXAMINATION

Sight

Use of glasses or contact lenses: Yes/No (if yes, specify which type and for what purpose)

	Visual acuity						Visual fields			
	Unaided			Aided			Normal	Defective		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular				
Distant							Right eye			
							Left eye			

Color vision	<input type="checkbox"/> Not tested	<input type="checkbox"/> Normal	<input type="checkbox"/> Doubtful	<input type="checkbox"/> Defective
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Hearing

	Pure tone and audio metry (threshold values in dB)						Speech and whisper test (metres)			
							Normal	Whisper		
	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz						
Right ear							Right ear			
Left ear							Left ear			

Clinical data

Height: _____ (cm) Weight: _____ (kg)

Pulse rate: _____ (/minute) Rhythm: _____

Blood pressure: Systolic : _____ (mmHg) Diastolic : _____ (mmHg)

Urinalysis: Glucose: _____ Protein: _____ Blood: _____

	Normal	Abnormal		Normal	Abnormal
Head	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	Varicose venis	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/teeth	<input type="checkbox"/>	<input type="checkbox"/>	Vascular (inc. Pedal pulses)	<input type="checkbox"/>	<input type="checkbox"/>
Ears (general)	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	<input type="checkbox"/>	<input type="checkbox"/>
Tympanic membrane	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anus (not rectal exam.)	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmoscopy	<input type="checkbox"/>	<input type="checkbox"/>	G-U system	<input type="checkbox"/>	<input type="checkbox"/>
Pupils	<input type="checkbox"/>	<input type="checkbox"/>	Upper and lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Eye movement	<input type="checkbox"/>	<input type="checkbox"/>	Spine (C/S, T/S and L/S)	<input type="checkbox"/>	<input type="checkbox"/>
Lungs and chest	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic (full brief)	<input type="checkbox"/>	<input type="checkbox"/>
Breast examination	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	General appearance	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/> Not performed		<input type="checkbox"/> Performed (day /month /year) _____/_____/_____		

Results: _____

Other diagnostic tests and results:

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 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 With restrictions Visual aid required Si No

Describe restrictions (e.g. specific positions, type of ship, trade area)

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

Date of medical certificate issued (day/month/year): ____/____/____.

Number of medical certificate: ____

Name of medical practitioner (typed or printed): ____

License number of medical practitioner: ____

Address of medical practitioner: ____

Authorized by: Panama Maritime Authority

Signature of medical practitioner: _____

Seal: 