

MARITIME AND PORT AUTHORITY OF SINGAPORE SHIPPING DIVISION

RECORD OF MEDICAL EXAMINATIONS OF SEAFARER

Part A – to be completed by the Seafarer who is responsible for answering each question accurately.

Seafarer's Name in Full (BLOCK CAPITALS)		Sex: Male/Female
Date of Birth: day/month/year	Place of Birth:	Nationality:
Type of ID documents: NRIC No. / Passport No.:	Dept: Deck / Engine / Catering / others Rank:	Type of ship:
Home Address:	Routine and emergency duties:	Trading area: e.g coastal / world wide

Seafarer's Declarations *(please tick)*

Have you ever had any of the following conditions?

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

If you answer "yes" to any of the above questions, please provide 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 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?		
42. Are you using any non-prescription or prescription medication?		

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

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

_____ Date _____ Signature of Seafarer _____ Name and Signature of Witness

I hereby authorize the release of all my previous medical records (including my last Seafarer Medical Certificate) from any health professional, health institutions and public authorities to Dr. _____.

_____ Date _____ Signature of Seafarer _____ Name and Signature of Witness

Part B – Result of medical examinations

Eyesight

Use of glasses or contact lenses

No

Yes Type Purpose

Visual Acuity

Unaided			Aided		
Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant			Distant		
Near			Near		

Visual fields

	Normal	Defective
Right eye		
Left eye		

Colour Vision (please tick)

Not tested Normal Doubtful Defective

Hearing

Pure tone and audiometry (threshold values in dB)				
	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right ear				
Left ear				

Speech and whisper test (metres)

	Normal	Whisper
Right ear		
Left ear		

Clinical Findings

Height	(cm)		Weight	(kg)	
Pulse rate	(per minute)		Rhythm		
Blood Pressure	Systolic (mm Hg)		Diastolic (mm Hg)		
Urinalysis:	Glucose :		Protein:		Blood:

	Normal	Abnormal
Head		
Sinus, nose, throat		
Mouth/teeth		
Ears (general)		
Tympanic membrane		
Eyes		
Ophthalmoscopy		
Pupils		
Eye movement		
Lungs and chest		
Breast examination		
Heart		
Skin		
Varicose Vein		
Vascular (inc. pedal pulse)		
Abdomen and viscera		
Hernia		
Anus (not rectal exam)		
G-U system		
Upper and lower extremities		
Spine (C/s, T/S, L/S)		
Neurologic (full/brief)		
Psychiatric		
General appearance		

Chest X-ray

Not performed

Performed on (day/month/year):

Results:

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

Test

Results:

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

Assessment of fitness for service at sea *(please tick)*

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

Fit for look out duty

Unfit for lookout duty

Visual aid required

Visual aid not required

	Deck Service	Engine Service	Catering Service	Other Service
Fit				
Unfit				

Without restrictions

With restrictions

Description of restrictions (e.g. specific position, type of ship, trading area etc.)

Date

Signature of
Medical Practitioner

Medical Practitioner's name, licence number, address
