



Medical examination Shipping crew

This form is used by the medical examiner, in addition to more detailed examination, to determine if the candidate is fit for duty.

The medical examiner sends a registration of the personal data of the candidate and the outcome of the examination to the Medical Advisor of the IVW, including the reason of rejection if applicable.

The medical examiner keeps the examination data in a medical file.

The Medical Advisor has no access to the medical data without permission of the seafarer.

Contact the medical examiner for more information about this form.

1 Details seafarer

- 1.1 Surname and Gender Male Female
- 1.2 First names in full
- 1.3 Date of birth and place of birth
- 1.4 Nationality
- 1.5 Address
- 1.6 Postal code and place of residence
- 1.7 Telephonenumber(s)
- 1.8 Number seaman's book and country of issue

2 Details of own physician

- 2.1 Name
- 2.2 Address

3 Details work/education

- 3.1 Name ship owner / nautical college
- 3.2 Type of ship
- 3.3 Duties on board the ship
- 3.4 Sailing area

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Details of previous examinations

- 4.1 Have you ever been rejected as a seafarer? Yes No
- 4.2 Have you ever been certified fit with restrictions? Yes No
- 4.3 Have you ever had a medical exemption? Yes No
- 4.4 Date of the last medical examination
- 4.5 Details

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Details present examinations

- 5.1 Your examinations concerns
- Look-out or watch duties on the bridge
- Watch duties in the engine room
- Rating without look-out or watch duties

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Medical questions

- 6.1 Do you experience limitations in the performance of your duties? Yes No
- 6.2 Have you ever been repatriated due to illness? Yes No
- 6.3 Have you ever had an accident? Yes No
- 6.4 Have you ever had surgery? Yes No
- 6.5 Can you use your hands and feet without limitations in motion and touch? Yes No
- 6.6 Are you allergic to any substances? Yes No
- 6.7 Does night-blindness give you any trouble? Yes No
- 6.8 Do you wear glasses or contact lenses? Yes No
- 6.9 Is your colour vision normal? Yes No
- 6.10 Have you had eye surgery or laser treatment? Yes No
- 6.11 Do you use a hearing-aid? Yes No
- 6.12 Do you take any medication? If so, which? Yes No
- 6.13 Do you drink alcohol? If so, how many drinks per week? Yes No
- 6.14 Do you smoke? If so, how much per day? Yes No
- 6.15 Did you use drugs during the past 5 years? Yes No
- 6.16 Are you pregnant? Expected date of delivery? Yes No N.a.
- 6.17 Do you have painful or irregular periods? yes No N.a.
- 6.18 When was your last visit to the dentist?
- 6.19 Details

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Physical complaints

7.1 Do or did you suffer from any of these conditions?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contagious diseases, tropical diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trombosis or embolism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy, seizures or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drinking problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous strain, depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fear of heights / open spaces / claustrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insomnia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Somnambulism, bed-wetting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin diseases, eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Venereal diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inguinal hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Varicose veins, haemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Severe headache, dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Syncope, fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low vision or blurred vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poor hearing or ringing in the ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing, shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma, bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain, palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen feet, especially in the evening	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach-ache, nausea, low appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal pain, cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Black or discoloured stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Strain or pain with urinating

Pain in the back

Painful arms, legs or joints

Fractures, dislocations

Seasickness

7.2 Details

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Signature

The undersigned is aware of the fact that due to false or inaccurate completion of this medical history the medical examination may be considered invalid. The undersigned therefore certifies that the personal declaration above is a true statement to the best of his or her knowledge.

8.1 Place and date

8.2 Signature

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9 Details examination and medical examiner

- 9.1 Date of examination _____
- 9.2 Name medical examiner _____

10 Physical examination

- 10.1 Length and body weight _____
- 10.2 Quetelet _____
- 10.3 Waist circumference (optional) _____
- 10.4 Pulse rate and blood pressure _____
- 10.5 General physical appearance _____
- 10.6 Psyche _____
- 10.7 Skin _____
- 10.8 Lymph nodes _____
- 10.9 Neck / thyroid _____
- 10.10 Mouth / throat / nose _____
- 10.11 Dental status _____
- 10.12 Speech _____
- 10.13 Heart _____
- 10.14 Lungs _____
- 10.15 Abdomen _____
- 10.16 Genital organs, groins _____
- 10.17 Upper extremities _____
- 10.18 Lower extremities _____
- 10.19 Spine _____
- 10.20 Motor system _____
- 10.21 Co-ordination _____
- 10.22 Reflexes _____

11 Fitness and physical abilities

- 11.1 Climb up and down vertical ladders Sufficient Inadequate _____
- 11.2 Step over coamings (60cm) Sufficient Inadequate _____
- 11.3 Grasp, lift, manipulations Sufficient Inadequate _____
- 11.4 Reach above shoulder height Sufficient Inadequate _____
- 11.5 Stoop, crouch, kneel and crew Sufficient Inadequate _____
- 11.6 Stand and walk a watch for extended periods Sufficient Inadequate _____
- 11.7 Move through a restricted opening of 60x60 cm Sufficient Inadequate _____

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12 Vision / eyes

12.1	Visual acuity, unaided	OD	OS	ODS
12.2	Visual acuity, aided	OD	OS	ODS
12.3	Near vision, aided			ODS
12.4	Reading a monitor at a distance of 70 cm			ODS
12.5	Visual fields	OD	OS	
12.6	External	OD	OS	
12.7	Eye movements	OD	OS	
12.8	Pupillary reflex	OD	OS	
12.9	Signs of double vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12.10	Spare glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Colour vision

12.11	Ishihara 2 or more mistakes	<input type="checkbox"/> No	<input type="checkbox"/> Yes (detailed examination required)	
12.12	Specialist colour test	<input type="checkbox"/> Sufficient	<input type="checkbox"/> Defective	
12.13	Specialist colour test used, plus results			

More detailed examination required

12.14	Night-blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12.15	Ophthalmoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

13 Hearing/ ears

13.1	Conversational speech	AD	m	AS	m
13.2	Tone-audiometric loss 500 Hz.	AD	dB	AS	dB
13.3	Tone-audiometric loss 1000 Hz.	AD	dB	AS	dB
13.4	Tone-audiometric loss 2000 Hz.	AD	dB	AS	dB
13.5	Tone-audiometric loss 3000 Hz.	AD	dB	AS	dB
13.6	Tone-audiometric loss average	AD	dB	AS	dB
13.7	Otoscopy	AD			
		AS			

14 Compulsory diagnostic tests

14.1	Does the candidate come from an area with a high prevalence of tuberculosis?	<input type="checkbox"/> Yes (Examination on tuberculosis obligatory)	
		<input type="checkbox"/> No (Examination on tuberculosis depending on sailing area)	
14.2	X-thorax / Mantoux date, plus results		
		<i>No chest X-ray or Mantoux: the area of validity on the medical certificate will be: Limited as a result of absence of the examination on tuberculosis)</i>	
14.3	Blood group		
14.4	Urine:		
	Protein		
	Glucose		
	Blood		

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15.1 Remarks

15 Additional diagnostic tests

16.1 Remarks

16 Specialist report

17.1 Remarks

17 Family history

18.1 Remarks

18 Consultation with attending physician

19.1 Remarks

19 Comments, notes

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20 Validation exemptions

20.1 The exemptions given by the medical advisor are valid until?

Exemption with regard to general medical fitness: _____

Exemption with regard to the visual system: _____

Exemption with regard to the auditory system: _____

21 Conclusion seafarer's examination

21.1

Compiles to the medical standards of	Look-out or watch duties on the bridge			Watch duties in the engine room			Rating without look-out or watch duties		
	Yes	Exemption *	No	Yes	Exemption *	No	Yes	Exemption*	No
Medical fitness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONCLUSION	<input type="checkbox"/> Fit for duty *		<input type="checkbox"/> Unfit **	<input type="checkbox"/> Fit for duty *		<input type="checkbox"/> Unfit **	<input type="checkbox"/> Fit for duty*		<input type="checkbox"/> Unfit **

* The expiry date of the Seafarer medical certificate may never exceed the expiry date on the exemption.

** A candidate is unfit if "No" is used once, unless the candidate is in use of a valid exemption.

21.2 Restrictions to area of validity

21.3 Restrictions to period of validity
