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 ☐ FEMALE ☐
POSITION ON BOARD: MASTER ☐ DECK OFFICER ☐ ENGINEERING OFFICER ☐ RADIO OPERATOR ☐ RATING ☐	MAILING ADDRESS OF APPLICANT:	

DECLARATION OF THE AUTHORIZED PHYSICIAN

VISION			COLOR TEST TYPE	HEARING
	WITHOUT GLASSES	**WITH GLASSES**	☐ BOOK	
RIGHT EYE	_____	_____	☐ LANTERN YELLOW _____ RED _____	RIGHT EAR _____
LEFT EYE	_____	_____	GREEN _____ BLUE _____	LEFT EAR _____

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 APPROPIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFCIER / 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 EXAMINATIOS

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	☐	☐	19.	Do you smoke,use alcohol or drugs?	☐	☐
2.	High blood pressure	☐	☐	20.	Operation/surgery	☐	☐
3.	Heart/vascular disease	☐	☐	21.	Epilepsy/ seizures	☐	☐
4.	Heart surgery	☐	☐	22.	Dizziness/fainting	☐	☐
5.	Varicose veins/piles	☐	☐	23.	Loss of consciousness	☐	☐
6.	Asthma/bronchitis	☐	☐	24.	Psychiatric problems	☐	☐
7.	Blood disorder	☐	☐	25.	Loss of consciousness	☐	☐
8.	Diabetes	☐	☐	26.	Attempted suicide	☐	☐
9.	Thyroid problems	☐	☐	27.	Loss of memory	☐	☐
10.	Digestive disorder	☐	☐	28.	Balance problems	☐	☐
11.	Kidney problems	☐	☐	29.	Severe headaches	☐	☐
12.	Skin problems	☐	☐	30.	Ear (hearing/ tinnitus) nose/throat problems	☐	☐
13.	Allergies	☐	☐	31.	Restricted mobility	☐	☐
14.	Infectious/contagius diseases	☐	☐	32.	Back or joint problems	☐	☐
15.	Hernia	☐	☐	33.	Amputation	☐	☐
16.	Genital disorders	☐	☐	34.	Fractures/dislocation	☐	☐
17.	Pregnancy	☐	☐			☐	☐
18.	Sleep problem	☐	☐			☐	☐

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?	☐	☐
36.	Have you ever been hospitalized?	☐	☐
37.	Have you ever been declared unfit for sea duty?	☐	☐
38.	Has your medical certificate ever been restricted or revoked?	☐	☐
39.	Are you aware that you have any medical problems, diseases or illness?	☐	☐
40.	Do you feel healthy and fit to perform the duties of your designed position/occupation?	☐	☐
41.	Are you allergic to any medications?	☐	☐

Comments:

		SI	**NO**
42.	Are you taking any non-prescription or prescription medications?	☐	☐

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					
	Unaides			**Aided**		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant						

	Visual fields	
	Normal	**Defective**
Right eye		
Left eye		

Color vision	☐Not tested	☐Normal	☐Doubtful	☐**Defective**

Hearing

	Pure tone and audio metry (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 data

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

Pulse rate: _____ (/minute) Rhythm: _____

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

Urinalysis: Glucose: _____ Protein: _____ Blood: _____

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

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: