CURACAO ISLAND
MARITIME ADMINISTRATION

Web: www.ims-registry.org Email: certification@ims-registry.org

Medical Examination FORM for STCW or STCW-F Seafarers

IMPORTANT

This form is for **Approved Medical Practitioners** who are examining seafarers that have STCW or STCW-F maritime certificates.

Section 1: Seafarer declaration

Surname: First name(s): _____

Date of birth: (day/month/year): _____ Gender: ☐ Male ☐ Female

Home address: _____

Identity document type: _____ No.: _____

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

Trade area (eg inshore, coastal, unlimited): _____

Examinee's personal declaration

(Assistance should be offered by medical staff)

Condition		Yes	No	Condition		Yes	No
1.	Eye/vision problem	O	O	18.	Sleep problems	O	O
2.	High blood pressure	O	O	19.	Smoker	O	O
3.	Heart/vascular disease	O	O	20.	Operation/surgery	O	O
4.	Heart surgery	O	O	21.	Epilepsy/seizures	O	O
5.	Varicose veins	O	O	22.	Dizziness/fainting	O	O
6.	Asthma/bronchitis	O	O	23.	Loss of consciousness	O	O
7.	Blood disorder	O	O	24.	Psychiatric problems	O	O
8.	Diabetes	O	O	25.	Depression	O	O
9.	Thyroid problem	O	O	26.	Attempted suicide	O	O
10.	Digestive disorder	O	O	27.	Loss of memory	O	O
11.	Kidney problem	O	O	28.	Balance problem	O	O
12.	Skin problem	O	O	29.	Severe headaches	O	O
13.	Allergies	O	O	30.	Ear/nose/throat problems	O	O
14.	Infectious/contagious diseases	O	O	31.	Restricted mobility	O	O
15.	Hernia	O	O	32.	Back problems	O	O
16.	Genital disorders	O	O	33.	Amputation	O	O
17.	Pregnancy	O	O	34.	Fractures/dislocations	O	O

If any of the personal declaration questions were answered “yes”, please give details below:

Additional questions

		Yes	No
35.	Have you ever been signed off as sick or repatriated from a ship?	O	O
36.	Have you ever been hospitalised?	O	O
37.	Have you ever been declared unfit for sea duty?	O	O
38.	Has your medical certificate ever been restricted or revoked?	O	O
39.	Are you aware of having any medical problems, diseases or illness?	O	O
40.	Do you feel healthy and fit to perform the duties of your designated position/occupation?	O	O
41.	Are you aware of being allergic to any medications?	O	O

Comments:

		Yes	No
42.	Are you taking any prescription or non-prescription medications?	O	O

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

Seafarers should note that under Rule 34.22(2) they should supply their vaccination record to the approved medical practitioner if applying for an “unlimited areas” certificate.

Seafarers must complete section 1 of the form. The doctor will complete section 2.

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:

Signature *Typed or printed name*

I hereby authorise 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: _____ Name: _____

Signature *Typed or printed name*

Privacy protection

The information collected on this form is protected by the provisions of the Privacy Act 1993 and the Health Information Privacy Code 1994. The information is collected for the purpose of an approved medical practitioner determining the applicant's fitness for intended work as a seafarer. The collection of the information is required by Maritime Rule Part 34 made under the Maritime Act 2010. Failure to provide the information required may result in a failure to pass the medical examination. The applicant has the right of access to, and correction of, any personal information contained on this form.

Section 2: Medical examination

○ Pre-sea ○ Periodic ○ Other (please specify): _____

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

	Visual fields	
	Normal	Defective
Right eye		
Left eye		

Colour vision: ○ Not tested ○ Normal ○ Doubtful ○ Defective

	Hearing					
	Pure tone and audiometry (threshold values in dB)					
	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right ear						
Left ear						

Speech and whisper test (metres)

	Normal	Whisper
Right ear		
Left ear		

Height (cm): _____ Weight (kg): _____ Body mass index: _____

Pulse rate: _____ / (minute) Rhythm: _____

Blood pressure: Systolic: _____ (mm Hg) Diastolic: _____ (mm Hg)

Urinalysis: Glucose: _____ Protein: _____ Blood: _____

	Normal	Abnormal		Normal	Abnormal
Head	○	○	Skin	○	○
Sinuses, nose, throat	○	○	Varicose veins	○	○
Mouth/teeth	○	○	Vascular (incl pedal pulses)	○	○
Ears (general)	○	○	Abdomen and viscera	○	○
Tympanic membrane	○	○	Hernia	○	○
Eyes	○	○	Anus (not rectal exam)	○	○
Opthalmoscopy	○	○	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 on (day/month/year) //

Results:

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

Test: _____ Result: _____

Approved medical practitioner's comments:

Vaccination status recorded: ○ Yes ○ No

Section 3: Assessment of fitness for service at sea

On the basis of the examinee's personal declaration, my clinical examination, and diagnostic test results recorded on the medical examination form, I declare the examinee's medical category under Maritime Rule Part 34.25(2) is:

(Medical category letter)	(Medical category explained in text)

Describe restrictions (eg specific position, type of ship, trade area)

I confirm that:

- ☐ hearing and sight are satisfactory for duties in the capacity of: _____
- ☐ he/she* is fit/not fit* for lookout duties (deck department only): _____

Action taken by approved medical practitioner (eg referral):

Place of examination:		Date of examination (day/month/year):	/ /

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

Official stamp (also print name of approved medical practitioner if not legible):

Signature of approved medical practitioner:

_____ _____