THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF WORKS AND TRANSPORT
TANZANIA SHIPPING AGENCIES CORPORATION
TASAC

PSSSF GARDEN AVENUE TOWER
7TH AND 8TH FLOOR, PLOT NO. 20/21,
GARDEN AVENUE/OHIO STREET,
P. O. BOX 989 DAR ES SALAAM,
TEL: +255 222 127 314,
FAX: +255 222 127 313,
Web Site: www.tasac.go.tz
Email: dg@tasac.go.tz

Our Ref: MB 113/384/01/ **Date:**

Medical Examination Request Form
(To be completed by the Seafarer's employers or TASAC)

To: **Dr…….**

Address:

Telephone:

Mobile:

E mail:

Please carry out a: (i) pre-sea*
(ii) periodic* health assessment of
(iii) other*

……

For the position of …….

Yours Sincerely,

Please keep all the Medical Examination forms in your confidential files in accordance with normal medical practice and return a copy of the certificate of Medical Fitness/together with your account to:

REGISTRAR
TASAC

* delete where not applicable

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF WORKS AND TRANSPORT
TANZANIA SHIPPING AGENCIES CORPORATION
TASAC

Medical Fitness Certificate

Name …… …….. ….....
Last Name First Names Middle Name

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

Nationality .....

Home address …….

Proof of identity: Kind of identity ……. Number …….
(e.g., National ID, CDC, Driver's License, Passport)

I have evaluated the above named applicant according to the Merchant Shipping (Medical Examination) Regulations, 2016, made under the Merchant Shipping Act, 2003. On the basis of the applicant's personal declaration, my clinical examination and diagnostic test results recorded on the medical examination form, I declare the applicant fit for seafaring

The applicant used aids to vision to meet a satisfactory standard _____ Yes _____ No

Date of last colour vision test if not tested at this examination _____

The applicant used aids to hearing to meet a satisfactory standard _____Yes _____ No

Date of examination …….. Place of examination……..
(Day/month/year)

Name of Approved Medical Practitioner …… Official Stamp

Signature of Approved Medical Practitioner……..

Expiry date of Certificate …….
(day/month/year)

PHOTO

I acknowledge that I have been advised on the content of the medical examination form.

Applicant's signature ……

The original of this Certificate is given to the applicant. A copy is to be provided to TASAC. The Approved Medical Practitioner may retain a copy.

Please complete this questionnaire prior to attendance, but leave blank the answer to any question you do not understand. You must bring a suitable means of identification (passport, certificate of competence, driving license) with you to the examination.

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF WORKS AND TRANSPORT
TANZANIA SHIPPING AGENCIES CORPORATION
TASAC

Medical Examination Questionnaire

Name: _____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

NATIONALITY: _____

Date of birth _____ ☐ Male ☐ Female

Home Address _____

Name, address and phone number of treating doctor: _____

Proof of identity (Eg. National ID, CDC, Passport, Driving license) _____

Type of ship (e.g., container, Tanker, Passenger, Bulk carrier _____ Department _____

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

The following should be signed in presence of the examining medical officer.

Declaration
I hereby declare that my personal statements are true and correct to the best of my knowledge.

…….. ……
Applicant's signature *Date*

Authority to divulge medical information
If, as a result of this or subsequent examinations for the purposes of assessing my medical fitness for duty at sea, the examining medical officer requires relevant medical details from my treating medical advisor (s), permission is hereby granted to obtain information from:

Dr. ……. Dr. ……. Dr. ……

…….. ……
Applicant's signature *Date*

Privacy Note. Please read carefully for information and guidance.
The information contained in this form and its associated documents will only be used for the purpose of assessing your medical fitness for duty at sea and for TASAC audit purposes. This information will only be exchanged between your examining medical officer and your treating medical practitioner and/or any medical panel convened to assess your fitness for duty at sea. If you do not meet the medical fitness standard for duty at sea, you and your employer will be advised of this on the Medical Fitness Certificate. A copy of this questionnaire is to be forwarded by the Approved Medical Practitioner after the examination is completed. The approved Medical Practitioner may retain a copy of this questionnaire for record purpose.

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF WORKS AND TRANSPORT
TANZANIA SHIPPING AGENCIES CORPORATION
TASAC

For the purposes of certificate under STCW 1978 as amended.

IMPORTANT NOTE

This document is NOT a Certificate of Medical Fitness and does NOT meet the requirements of the Merchant Shipping (Medial Examination) Regulations 2016, for a Medical Fitness Certificate. It is intended solely to permit the holder to obtain or renew a certificate under the Merchant Shipping (Training, Certification and Manning) Regulations, 2016 in accordance with the International Convention on Standards of Training, Certification and Watch keeping for Seafarers, 1978 as amended.

Name _____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

Gender: Male ____ Female: ____ Date of Birth (day/month/year): ____/____/____

Nationality _____

Home address: _____

Proof of identity: (e.g., National ID, CDC, Driver's License, Passport _____

I have evaluated the above – named applicant according to the Merchant Shipping (Medical Examination) Regulations, 2016, made under the Merchant Shipping Act, 2003. On the basis of applicant's declaration, my clinical examination and diagnostic test result recorded on the medical examination form, I declared that:

- The applicant is not medically fit to perform duties as a seafarer or as a coastal pilot on a ship, because of temporary/permanent condition or disability
- The applicant cannot be certificated as medically fit as a full medical examination has not been carried out
- The applicant meets the medical fitness standard in , regulation 13(2) of the Regulations, relating to eyesight, colour vision and hearing

Date of examination (day/month/year) ____/____/____ Place of Examination _____

Date of last vision test if not tested at this examination _____

Name of Approved Medical Practitioner _____ Official stamp

Signature Approved Medical Practitioner _____

Expiry date of Certificate (day/month/year) ____/____/____

I acknowledge that I have been advised of the content of the examination form.

Applicant's Signature: _____

EXAMINATION PERSONAL DECLARATION

All questions must be answered

Have you now or have you previously had any of the following condition? Circle YES or NO in space provided.

	Medical Practitioner's Comment. **Require on any affirmative answer**
1. a) High blood pressure Yes/No b) Coronary artery Yes/No c) Operation on the heart Yes/No d) Pain in the chest Yes/No e) Palpitations Yes/No f) Rheumatic fever Yes/No g) Disease of the heart or blood vessels Yes/No h) Anaemia or any other disease of the blood Yes/No i) Abnormal bleeding Yes/No j) Swelling of the ankles Yes/No k) Varicose vein Yes/No	
2. a) Indigestion or dyspepsia Yes/No b) Biliary disease Yes/No c) Disease of the liver including jaundice hepatitis) Yes/No d) Disease or ulcers of the stomach or duodenum Yes/No e) Disease of bowels Yes/No f) Haemorrhoids (piles) Yes/No g) Hernia Yes/No h) Appendicitis Yes/No i) Recurrent abdominal pain / discomfort j) Recent change in weight Yes/No k) Difficult/ pain in swallowing Yes/No	
4. a) Asthma Yes/No b) Bronchitis or emphysema Yes/No c) Tuberculosis Yes/No d) other lung disease Yes/No e) Persistent cough Yes/No) f) persistent breathlessness Yes/No g) Collapsed lung Yes/No h) Abnomal chest X-ray in the past Yes/No	
5. a) Infection of bladder Yes/No b) difficulty in passing the urine Yes/No c) Any abnormality of the urine Yes/No d) kidney disease of kidney stone Yes/No e) sexually transmitted disease Yes/No	

6. a) Lumbago, sciatic or other back trouble Yes/No b) Any form of arthritis or stiff joint Yes/No c) Slipped disc or back and neck pain Yes/No d) Broken bones / Amputation Yes/No e) Joint injury Yes/No f) Injury of the neck or back Yes/No g) Repetitive strain injury, tennis elbow, tendonitis Yes/No h) Restricted mobility Yes/No	
7. a) mental or nervous condition or weakness Yes/No b) Anxiety state Yes/No c) Epilepsy or fits Yes/No d) Persistent headache Yes/No e) Dizziness / fainting Yes/No f) Persistent hoarse Yes/No k) Sleep problem Yes/No f) Attack of unconsciousness or weakness Yes/No g) Migraine Yes/No h) Disturbance or sensation or muscular activity Yes/No i) Poliomyelitis or other paralysis Yes/No j) Balance problem Yes / No	
8. a) Any form of cancer Yes/No b) Any lumps or other tumors Yes/No	
9. a) Goiter or Thyroid disease Yes/No b) Diabetes Yes/No c) Any other endocrine tumors Yes/No	
10. a) Skin eruption Yes/No b) Dermatitis or eczema Yes/No	
11. a) allergy conditions including fever Yes/No b) any abnormality of the immune system Yes/No c) any reaction to serum, drug or medicine (Including anesthetic agents) and vaccines Yes/No	
12. a) Malaria, typhoid, amoebiasis or giardia Yes/No b) Any other tropical disease Yes/No c) Contagious disease Yes /No	
13. a) Severe tooth or gum trouble Yes/No b) Impacted wisdom teeth Yes/No	

14. a) Any obstetric or gynecology problem Yes/No b) Are you pregnant Yes/No c) Genital disorder Yes/No	
15. a) Any eye disorder Yes/No b) Any injury to eyes Yes/No c) Any condition requiring glasses or contact lenses to be worn Yes/No • if you wear glasses, corneal or contact lenses, bring them with you to examination TINTED LENSES MUST NOT BE WORN	

Please give details of

16. Any complaint, illness or injury not mentioned …… …… ……	
17. Absences from work due to sickness or injury over past two years …… …… ……	
18. All accidents, surgical treatment or operations …… …… ……	
19. Are you in good health and fit to perform the duties of your designated position? ……	
20. Are you taking any medication at present? …… ……	
21. Are you allergic to any medications? ……	
22. When did you last receive medical, chiropractic, surgical or other treatment and for what condition? …… ……	
23. Are you aware of any circumstances reading your health which will interfere with the satisfactory discharge of the duties of your designated position/occupation?	
24. Have you ever had a Mantoux test for tuberculosis (TB)? Yes /No If yes, what was the result? …… Have you had a BCG vaccination against tuberculosis? Yes/No. Have you been immunized against the following What year? Polio: Yes/No Tetanus Yes/No Diphtheria: Yes/No TB: Yes/No Hepatitis A Yes/No Hepatitis B Yes/No Typhoid: Yes/No Yellow fever: Yes/No COVID 19 Yes/No	

25. Do you or have you ever smoked tobacco? Yes/No If yes: Do you currently smoke: Yes/No How much each day? …… If no, how long ago did you stop smoking? ……..	
26. Do you use alcohol or drug? Yes/No If yes, how much and how often	
27. Do you do any regular exercise? Yes/No If yes, what sort and how often	
28. Have you ever been signed off as sick or repatriated from a slip? Yes/No if yes give details	
29. Have you ever been declared unfit for duty at sea? Yes/No If yes state when, for how long and for what reason.	
30. Has your Medical Fitness Certificate ever been restricted or revoked? Yes/No if yes, give details	

APPROVED MEDICAL PRACTITIONER TO NOTE HERE ANY SIGNIFICANT MEDICAL CONDITIONS WHICH MAY BE A RISK FOR WORK AT SEA REMOTE FROM MEDICAL FACILITIES

Approved Medical Practitioner's Report

1. General appearance of the applicant
   a) physique
   b) presence of deformities
   c) mobility
   d) obesity
   e) any other comments

2. HEIGHT/WEIGHT

   a) Height (without shoes)…….meters
      Weight ……kg
   b) Body Mass Index (BMI) = Weight, kg
      (Height in m)^2 ……

3. VISION
   a) is there any visual defect of the eyes Yes/No
   The visual acuity of each eye should be tested with Snellen's Charts, and the result recorded

Visual acuity

	Unaided		Aided	
	Right	Left Binocular	Right	Left Binocular
Distant				
Near				

c) Does the applicant suffer from some degree of color blindness as determined by ishihara plates?

Colour Vision:

Not tested ☐ Normal ☐

Doubtful ☐ Defective ☐

Colour vision need not tested if a test has been completed within the previous 6 years.
Date of last colour vision test not tested at this examination
…….

MEDICAL INSPECTOR'S COMMENTS REQUIRED ON ANY ABNORMALITY

b) Are the visual fields satisfactory?

Visual fields to confrontation		
	Normal	Defective
Right eye		
Left eye		

d) Ishihara test: Pass/Further testing needed
e) List plates with errors:
f) Latent test: Required/Not Required
   colored wire test
g) in good lighting Pass Fail/Not applicable
h) Further testing on board ship

<table>
<tr><td colspan="2">4. MOUTH/TEETH

a) Is there any disease or abnormality of moth, throat or neck Yes/No

b) Are there any defect in teeth? Yes/No
Please give details
c) Is there any disease of the nose or sinuses? Yes/No</td><td></td></tr>
<tr><td colspan="2">5. SPEECH/HEARING BALANCE

a) Is there any defect in speech? Yes/No
b) Is there any disease of the ears Yes/No
c) Is any defect in hearing? Yes/No
d) Romberg’s test normal? Normal/Abnormal</td><td>Conversation Test at 3 meters
<table><tr><td></td><td>speech</td></tr><tr><td>Both ears together</td><td>/10</td></tr></table>
Conversation set only required if hearing loss in the better ear is more than 30dB at 500 to 2000Hz</td></tr>
<tr><td></td><td>Pure tone and audiornetory (threshold values in dB</td><td rowspan="4"></td></tr>
<tr><td></td><td>500 Hz 1000 Hz 2000 Hz 3000 Hz 4000 Hz 6000 Hz</td></tr>
<tr><td>Right ear</td><td></td></tr>
<tr><td>Left ear</td><td></td></tr>
</table>

6. CARDIOVASCULAR

a) After examination are you satisfied that the cardiovascular system is clinically within normal limits? If not give reasons in full.
b) Pulse: ……/min Rhythm ……..
c) Blood pressure readings:
Systolic …… Diastolic ……
d) If this reading is above 150/95 please take further readings after rest
Systolic …… Diastolic ……
e) Heart sound/apex beat Normal/ abnormal
f) Is there any history or evidence of taking antihypertensiv medication?
g) ECG Report (attach report and tracing to page 40. stress ECG required if clinically indicated. Baseline tracing only to be attached to this document.)

h) Does the applicant suffer from oedema or varicose vein?
Yes/No
If yes, state severity.

i) are carotid/peripheral pulses normal? Yes/No

ECG result

Stress ECG result (if clinically indicated)

7. RESPIRATORY

a) After examination are you satisfied with the clinical condition and efficiency of the respiratory system and chest? If not, give reason.

Trachea: Midline/ Abnormal
Chest expansion: 5cm/abnormal
Breath sound: Normal/abnormal

SPIROMETRY

	Actual	Predicted	%predicted
FEV_1			
FVC			
FEV_1 / FVC			

Spirometry FEV_1 <65% required further review
FVC <70% required review
FEV_1 / FVC <70% required review

b) Chest X-ray report Normal/Abnormal Date ……
attached report to page 40
(Chest X- rays are required for pre – sea medicals or it clinically indicated.)

8. GASTROINTESTINAL RENAL a) Is there any disease or abnormal of abdominal organs? If yes, give particulars Yes/No b) Is there any hemia present? Yes/No c) Is the liver enlarged? Yes/No d) Any renal bruits? Yes/No	
Urine dipstick results Faecal cultures: Normal/Abnormal (catering staff only) If abnormal, seek advice from infections disease specialist. Hepatitis A date of last Vaccination: Hepatitis A vaccine: Given/Not given	Glucose Normal/Abnormal Protein Normal/Abnormal Blood Normal/Abnormal Other
9. NEUROLOGICAL/PSYCHIATRIC a) is there any evidence of organic disease of the brain, spinal cord, or nerves? b) I s there any evidence of mental or nervous disorder including psychoses? Yes/No c) Is there any evidence suggestive of anxiety of panic disorder? Yes/No	
10. MUSCULOSKELETAL a) Does the applicant have normal use of the legs and arms? b) Is gait normal? Yes/No c) Are the bones and joints free of any defects? Yes/No d) Are joint movement in normal range and pain free Yes/No e) Any restriction or pain in movement of spine? Yes/No	
11. SKIN/LYMPH NODE a) Is there any skin disease including solar keratoes BCCs, eczema etc. Yes/No b) Are there any significant scars, ulcers, or enlarged lymph nodes? c) Are there any skin grafts? Yes/No d) are there any identifying marks on the skin? Yes/No	

A copy of this document is to be forwarded to: **REGISTRAR - TASAC**