Our Ref: MB 113/384/01/ **Date: ……**

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

To: **Dr. Charles K. Otito (M.D, MMED)**

Address: EDEN Medical Clinic
Mavuno House, Azikiwe Street
P.O. Box 65202, **DAR ES SALAAM**

Mobile: +255 754 438 812 / +255 0719 576 091

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 Medical Fitness Certificate /together with your account to:

THE REGISTRAR OF SEAFARERS
TASAC

* delete where not applicable

Medical Fitness Certificate

Name …… ……..
Last Name First Names

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

Home address …….

Proof of identity: Kind of identity ……Number …….

I have evaluated the above named applicant according to the Merchant Shipping (Medical Examinations) 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 …….. (Day/month/year) Place of examination……..

Name of Approved Medical Practitioner …… ……. …….. Official Stamp

Signature of Approved Medical Practitioner……..

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

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 and another copy 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.

Medical Examination Questionnaire

Name: _____ _____

LAST NAME FIRST NAME

Date of birth _____ Male ☐ Female ☐

Home Address _____

Name, address and phone number of treating doctor:

_____

Proof of identity(e.g. photo license, passport) _____ assport/Driving License No: _____

Type of ship (container, tanker Passenger, fishing): _____

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

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*

The Maritime Administration 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.

MEDICAL STATEMENT

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 Examinations) 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 Names

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

Home address: _____

Proof of identity: kind of identity _____ _____
(eg. Photo driver's license/passport)

I have evaluated the above – named applicant according to the Merchant Shipping (Medical Examinations) 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 , in accordance with regulation 13(2) of the Merchant Shipping(Training, Certification and Manning)Regulations, 2016,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: _____

PERSONAL HISTORY

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.

1.	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 or turns 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	Medical Practitioner's Comment. **Require on any affirmative answer**
2.	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	
3.	a) Indigestion or dyspepsia Yes/No b) Gallbladder 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) Hemia (rapture) Yes/No h) Appendicitis Yes/No i) Recurrent abdominal j) Recent change in weight 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) Abdominal 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 dieses or back or neck pain Yes/No d) Broken bones 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	
7.	a) Discharge from ears or perforated eardrums Yes/No b) Ringing in the ears or disturbance of balance Yes/No c) Deafness Yes/No d) Nasal or sinus trouble Yes/No e) persistent husky voice of frequent sore throat 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 hey 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, amoebiais or giardia Yes/No b) Any other tropical 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	
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? ……	
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	
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 drink alcohol? 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

MEDICAL INSPECTOR'S COMMENTS REQUIRED ON ANY ABNORMALITY

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 …….
……..
……..

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

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

<table>
<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 rowspan="3"></td><td>Pure tone and audiornetory (threshold values in dB</td><td rowspan="3"></td></tr>
<tr><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><td></td></tr>
<tr><td colspan="2">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</td><td>ECG result

Stress ECG result (if clinically indicated)</td></tr>
</table>

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
……
……
……
……

Glucose	Normal/Abnormal
Protein	Normal/Abnormal
Blood	Normal/Abnormal
Other	

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

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: **THE REGISTRAR OF SEAFARERS - TASAC**