This Seafarer Medical Certificate complies with STWC 1/9 or ILO-73 and Bahamian and Maltese Medical Standards or as approved by Countries with a Reciprocal Recognition Agreement, "Guidance for conducting Medical Fitness Examination for Seafarers"

Royal Caribbean International · Celebrity Cruises · Azamara Club Cruises

EMPLOYMENT MEDICAL EXAM FORM A

(New and Returning Crew)

Family Name:	Given Name:		Gender: ☐ Male ☐ Female	Birth Date (day/month/year):	Crew Position:
Seaman's Book No.:	Crew I.D. No.:	ID Confirmed? ☐ Yes ☐ No	Passport No.:		Nationality:
City of Residence:	Country of Residence:	Vessel:	Type of Ship: ☐Container ☐Tanker ☐Passenger ☐Fishing		Trade Area: ☐Coastal ☐Tropical ☐Worldwide

DO YOU HAVE OR DID YOU EVER HAVE ANY OF THE FOLLOWING CONDITIONS?

	CONDITION	Yes	No
1.	Frequent Ear Infections		
2.	Hearing Loss / Hearing aids		
3.	Glaucoma		
4.	Conjunctivitis		
5.	Do you wear glasses / contact lenses		
6.	Eye injury / Eye Problems		
7.	Frequent Colds / Sinus Trouble		
8.	Viral/Mononucleosis/Chicken Pox/ Measles/Mumps		
9.	Nosebleed		
10.	Frequent Sore Throat		
11.	Swollen Glands		
12.	Asthma or Wheezing		
13.	Bronchitis		
14.	Tuberculosis (TB)		
15.	Pneumonia		
16.	Coughing up Blood		
17.	Shortness of Breath		
18.	Rheumatic Fever		
19.	Hepatitis: A ☐ B ☐ C ☐		
20.	High Blood Pressure		
21.	Chest Pain		
22.	Heart Attack / Angina / Irregular heart beat		
23.	Poor Circulation / Varicose veins		
24.	Other Heart Disease		
25.	Heart Surgery		
26.	Blood Disorder		
27.	Kidney Problem		
28.	Infections/Contagious diseases		
29.	Hernia		
30.	Attempted Suicide		
31.	Genital Disorders		
32.	Sleep Problems		
33.	Psychiatric Problems		
34.	Loss of Memory		
35.	Stroke		
36.	Abdominal Pain		
37.	Gastritis / Reflux / Gastric or Duodenal Ulcer		
38.	Frequent Diarrhea or Constipation		
39.	Bleeding from Stomach or Bowels		
40.	Jaundice / Gallbladder / Liver Problems		
41.	Do you feel healthy and fit to perform the duties of your designated position/occupation?		
42.	Hemorrhoids / rectal bleeding		
43.	Urinary infection / blood in urine/ kidney stones		
44.	Prostate Disease (males)		
45.	Hernias of any kind		

	CONDITION	Yes	No
46.	Syphillis / HIV / Gonorrhea		
47.	Breast Mass / Lumps /Tenderness		
48.	Skin problems / Rashes		
49.	Allergies/anaphylaxis to environment, chemicals, food or drugs		
50.	Hand or Wrist Pain / Problem		
51.	Joint Pains / Arthritis / Numbness in Extremities		
52.	Elbow Pain / Injury / Surgery		
53.	Shoulder Pain / Injury / Surgery		
54.	Knee Pain / Injury / Surgery		
55.	Feet Pain / Injury / Surgery		
56.	Sprains / Dislocations / Fractures		
57.	Neck Pain/ Scoliosis / Cervical Injury		
58.	Back pain / Injury / Sciatica		
59.	Amputations, prosthetics		
60.	Headaches / Dizziness / Loss of Consciousness / Migraines		
61.	Head Injury or Concussion		
62.	Seizures / Epilepsy / Receiving Medications for it		
63.	Nervous Breakdown / Depression /Anxiety		
64.	Muscular Weakness		
65.	Yellow Fever / Scarlet Fever / Malaria / Tropical Diseases		
66.	Cancer or tumors		
67.	Serious Accidents / Illness		
68.	Thyroid Disease		
69.	Balance Problem		
70.	Throat Problems		
71.	Restricted Mobility		
72.	Fractures/Dislocations		
73.	Diabetes / Type I ☐ II ☐		
75.	Have you signed off as sick or repatriated from a ship?		
76.	Have you ever been **Hospitalized**? For What?		
77.	Have you ever been declared unfit for sea duty?		
78.	Has your medical certificate ever been restricted or revoked?		
79.	Have you had **ANY** type of surgery?		
80.	Have you ever received a blood transfusion? Why?		
81.	Are you taking **ANY** medications? What?		
82.	Alternative Medicine or Treatment? What?		
83.	Do you drink alcohol? How much per day: _____ week: _____		
84.	Do you smoke? If yes, how much per day? _____		
85.	Are you aware that you have any medical problems, diseases, Illnesses?		

FEMALES:

86.	Are you or do you think you may be pregnant?		
87.	What was the date of your last menstrual period? _____		
88.	Gynecological / Female Problems		

TO BE COMPLETED BY PHYSICIAN

ALL "YES" RESPONSES ABOVE REQUIRE COMMENTS FROM THE EXAMINING PHYSICIAN IN ENGLISH

Question #:	Comments:

MEDICAL CONSENT/AUTHORIZATION/RELEASE

My signature below acknowledges that all statements provided by me in this application are true and correct to the best of my knowledge and belief, and I further authorize and consent to the release of any/all of my medical records from any source, including nations, insurance offices, doctors, hospitals, and/or other institutions or public authorities. This general medical release will also authorize the release of any/all of my psychological or psychiatric records or referrals. I UNDERSTAND THAT FALSIFICATION WILL BE GROUNDS FOR LOSS OF BENEFITS AND/OR TERMINATION OF EMPLOYMENT. My signature further acknowledges my consent to any/all physical examinations and diagnostic testing:

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

SIGNATURE OF EXAMINEE	DATE	WITNESS NAME *(please print)*	WITNESS SIGNATURE	DATE

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. _____ **(**approved medical examiner).

SIGNATURE OF EXAMINEE	DATE	WITNESS NAME *(please print)*	WITNESS SIGNATURE	DATE

I acknowledge that I have reviewed the above information with the Applicant and noted Comments as required. Physician Phone #: _____

PHYSICIAN SIGNATURE	PHYSICIAN NAME *(please print)*	PHYSICIAN PHONE NUMBER	DATE

FOR RCL OFFICE USE ONLY

Reviewed by NAME *(please print)*	SIGNATURE	DATE

This Seafarer Medical Certificate complies with STCW 1/9, IMO/ ILO-73 , MLC 2006 and Bahamian and Maltese Medical Standards or as approved by Countries with a Reciprocal Recognition Agreement, "Guidance for conducting Medical Fitness Examination for Seafarers"

PRE-EMPLOYMENT MEDICAL EXAM FORM B

CREW MEMBER INFORMATION

Family Name:	Given Name:		Gender: ☐ Male ☐ Female	Birth Date (day/month/year):	Crew Position:
Seaman's Book No.:	Crew I.D. No.:	ID Confirmed? ☐ Yes ☐ No	Exam Date:	Passport No.:	Nationality:
City of Residence:	Country of Residence:	Vessel:	Type of Ship: ☐Container ☐Tanker ☐Passenger ☐Fishing		Trade Area: ☐Coastal ☐Tropical ☐Worldwide

GENERAL

Height _____ Weight _____ Temp _____ Respiratory Rate _____ Pulse Rate _____ Rhythm _____

Urinalysis _____ Glucose _____ Protein _____ B/P Systolic _____ B/P Diastolic _____ Body Mass Index (BMI) _____

VISION

Visual Acuity							Color Vision		Field Vision	Vision Adequate for Position Per Flag State Requirements?
Vision	Unaided			Aided			☐Ishihara	☐Bostrom Kugelberg	R = WNL ___	☐ Yes ☐ No
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular	☐Snellen	☐Passed ☐Not Passed	L = WNL ___	
Distant							☐Normal	☐Doubtful		
Near							☐Defective	☐Not Tested		

PURE-TONE AUDIOMETER (THRESHOLD VALUES IN DB)

EAR	500hz	1000hz	2000hz	3000hz	4000hz	6000hz	8000hz
Right							
Left							

SPEECH AND WHISPER TEST (METERS)

Whisper Test: ☐Yes ☐No **If ABNORMAL perform Audiogram**

Information on the use of hearing protection provided? ☐Yes ☐No

Any subjective signs of impaired hearing or dizziness? ☐Yes ☐No

CHEST X-RAY

☐ **Not performed** ☐ **Normal** ☐ **Abnormal**

Performed on (day/month/year):

Results:

VACCINATIONS

Name of Vaccination	Date of last vaccination	Name of Vaccination	Date of last vaccination
Diphteria		Polio	
Tetanus		Varicella	
Typhoid		Hepatitis A & B	
Pertussis		**MMR Mandatory show proof of vaccine**	
Yellow fever			

REQUIRED TESTS

Attach ALL LAB TESTS to Original
All results must be in ENGLISH

Chest X-ray (attach report)	Pregnancy Test (all Females)	Blood Chemistry BUN, Creatinine, Glucose, ALT, AST, Uric Acid And Lipid Panel total Chol, HDL, LDL, Triglycerides	**EKG** (required ONLY if there's a history of High Blood Pressure)
VDRL/RPR/FTA (use one)	O&P (Food and Beverage Positions)		
CBC (complete blood count)	Hepatits A IgM, HBsAg and Anti HCV		
Routine Urinalysis	Urine Drug Test (Benzodiazepines, Amphetamines, THC, Opiates, Cocaine)		
Results requiring investigation			

PHYSICAL EXAM

HEENT	Normal	Abnormal	THORAX LUNGS	Normal	Abnormal	ABDOMEN	Normal	Abnormal	RECTAL	Normal	Abnormal
Mouth / Teeth			Percussion			Shape			Hemorrhoids		
Tonsils			Auscultation			Tenderness			Prostate		
Pharynx			**EXTREMITIES**	**Normal**	**Abnormal**	Masses			Fistula		
Ears/Tympanic Membrane			Varicose veins			Scars			**NECK**	**Normal**	**Abnormal**
Eyes/Eye Movement/Pupils			Edema			Hernia			Nodes		
Head			Scars						Motion		
Nose			Discoloration			Testicles			Thyroid		
EMOTIONAL / PSYCHIATRIC			Deformities			**PELVIC**	**Normal**	**Abnormal**	Lungs / Chest		
Status			**NEURO**	**Normal**	**Abnormal**	Status			Vascular pulse		
HEART	**Normal**	**Abnormal**	Motor			**BREASTS**	**Normal**	**Abnormal**	G-U System		
Rhythm			Sensory			Tenderness			Upper & Lower Extremities		
Murmurs			Reflexes			Masses			Spine (C/S, T/S and L/S)		
SKIN	**Normal**	**Abnormal**	**PULSES**	**Normal**	**Abnormal**				General Appearance		

RANGE OF MOTION

CERVICAL	Normal	Abnormal	ELBOW	Normal	Abnormal	LUMBAR	Normal	Abnormal	WRIST	Normal	Abnormal
Forward flex			Retained flex			Forward flex			Pronation		
Extension			Extension			Extension			Supination		
Lateral flexion			Pronation			Lat. Flex			Dorsiflexion		
Rotation			Supination			Rotation			Planer flexion		
Scars			Scars			Slr (sitting)			Abduct		
HIP			**FEET**			Slr (supine)			Adduct		
Flexion			Inspection			Scars			**KNEE**		
Extension			Arch status			**SHOULDER**			Retained flex		
Abduction			Deformities			Forward elev.			Extension		
Adduction			**ANKLE**			Backward elev.			Scars		
Int.rotation			Dorsal flex			Abduction					
Ext.rotation			Plantar flex			Adduction					
FINGERS			Inversion			Int. Rotation					
Flexion			Eversion			Ext. Rotation					
Extension			Scars			Scars					

Previous psychiatric and/or back conditions requires letter from specialist

Applicant questioned regarding current or previous psychiatric condition/diagnosis? ☐ Yes ☐No.
If applicant's answer is "Yes" please describe below

Applicant questioned regarding current or previous back/lumbar condition/diagnosis? ☐ Yes ☐No
If applicant's answer is "Yes" please describe below

ABNORMALITIES FROM PHYSICAL EXAMINATION

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 DUTY** : (crew member is not believed to be suffering from any sickness or physical or mental ailment making him unfit for service or which may endanger the health of the other persons onboard.)	☐ **NOT FIT FOR DUTY** for the following reason(s):	☐ **FIT AFTER DEFECT CORRECTED** (Describe):

	DECK SERVICE	ENGINE SERVICE	CATERING SERVICE (F&B)	OTHER SERVICES
Fit				
Unfit				

☐ **Without Restrictions** ☐ **With Restrictions** Are they able to perform all activities of their job? ☐ Yes ☐No

Describe restrictions (e.g. specific position, type of ship, trade area):

SIGNATURE

Forms without Physician contact information are not acceptable

MEDICAL EXAMINER NAME *(please print)* | MEDICAL EXAMINER SIGNATURE | DATE

ADDRESS | PHONE NUMBER

MEDICAL CERTIFICATE FOR SERVICE AT SEA

This Medical Certificate has been issued in accordance wit the provisions of the (International Convention on Standards of Training, Certification and Watch-keeping for Seafarers STCW 1978, as amended (STCW) Regulation I/9, Maritime Labour Convention 2006 (MLC 2006) Regulation 1.2 and regulation xxx of the authorizing country) as applicable.*

SEAFARER INFORMATION

Family Name:	Given Name(s):	Exam Date:	Birth Date *(day/month/year):*	Gender: ☐ Male ☐ Female
Passport No./Seaman Book No.:	Home Address:			
Nationality:	Capacity that the seafarer will serve onboard : Deck: ☐ Engineer ☐ Rating ☐ Catering (F&B) ☐ Other ☐			

DECLARATION OF APPROVED** MEDICAL PRACTITIONER

I confirm the identification documents were checked:	☐YES ☐NO	Color vision meets standard*?	☐YES ☐NO
Does the seafarer's hearing meet medical standards?	☐YES ☐NO	Date of last color vision test:	*(dd/mm/yyyy):*
Is unaided hearing satisfactory*?	☐YES ☐NO		
Vision acuity meets medical standards*?	☐YES ☐NO	Is the seafarer fit for service?	☐YES ☐NO
I have evaluated the above named examinee according to company medical guidelines.			☐YES ☐NO
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:		☐Fit ☐Not fit for look-out duty or ☐NA	
Is the seafarer free from any medical condition likely to be aggravated by service at sea or render the seafarer unfit for such service or to endanger the health of other persons onboard?			☐YES ☐NO

Are there any limitations or restrictions on fitness *(e.g. specific position, type of ship, trade area)*? If so, specify the limitation:

Place of examination:	Date of examination:	Medical certificate expiration date (day/month/year):

SIGNATURE

I hereby confirm that the medical examination has been carried out in accordance with the ILO/IMO Guidelines on the Medical Examinations of Seafarers and the national guidelines of my Authorizing Administration.

Official stamp and National License/Certification number

Medical examiner signature *(print name if not legible)*

*I _____ (seafarer name) confirm that I have been informed of the content of certificate and the right to get a review***.*

Examinee's signature

**For persons who are assigned shipboard safety, security or environmental protection duties, the medical standards referenced on the certificate are the standards as specified in STCW Regulation I/9 and any other standards as specified by the authorizing Administration. For any other persons serving onboard, the medical standards shall be as specified by ILO and the authorizing Administration.*

*** The Medical Practitioner shall be approved by the national Administration, after inspection of medical facilities/recordkeeping, to carry out STCW/ILO medical examination.*

***The review shall be carried out by a body/Medical Practitioner authorized by national Administration and this information should be made available to the seafarer.