PRE-EMPLOYMENT SEAFARER DECLARATION

This seafarer medical examination complies with STCW Code, section A-I/9 or ILO-73 or as approved by countries with a reciprocal recognition agreement, "Guidance for conducting medical fitness examination for seafarers."

First Name:	**Last Name:**
Registered sex at birth: Male ☐ Female ☐	**Date of Birth:**
Current gender: Male ☐ Female ☐ Other ☐	**Passport Number:**
Vessel:	**Nationality:**
Crew Position:	**Country of residence:**
Crew ID:	**Seaman's Book Number:**

Do you have, or ever have had any of the following conditions?
*If **YES,** enter details in the comments section including dates, outcomes and any medications taken*

	No	Yes
1. Infectious diseases including:		
Pulmonary TB, Syphilis, Hepatitis A, B, or C, HIV, Malaria or other	☐	☐
2. Tumours and lumps including:	**No**	**Yes**
Benign or malignant, including lymphoma, leukaemia and related conditions	☐	☐
3. Blood disorders such as:	**No**	**Yes**
Anaemia, sickle cell, thalassaemia and other diseases of the blood and blood forming organs (including removal of the spleen)	☐	☐
4a. Diabetes or **pre-diabetes**	**No**	**Yes**
Controlled by diet, medication or insulin	☐	☐
4b. Weight loss or weight gain	**No**	**Yes**
Unexpected or unexplained weight loss or gain	☐	☐
4c. Endocrine or metabolic disorders including	**No**	**Yes**
Thyroid, adrenal including Addison's disease, pituitary, ovary or testes	☐	☐
5a. Dependence / abuse:	**No**	**Yes**
Alcohol or drugs	☐	☐
5b. Mental, cognitive and behavioural disorders	**No**	**Yes**
Psychosis, schizophrenia, bipolar, anxiety, depression, ADHD, autism, PTSD, suicide attempts, insomnia	☐	☐
6. Diseases of the nervous system including:	**No**	**Yes**
Stroke / TIA, seizures, headache, sleep apnoea, narcolepsy, multiple sclerosis, Parkinson's, dizziness, fainting, head/brain injury or surgery, memory loss, dementia	☐	☐
7a. Eye disorders including:	**No**	**Yes**
Glaucoma, maculopathy, diabetic retinopathy, retinitis pigmentosa, keratoconus, diplopia, blepharospasm, uveitis, corneal ulceration and retinal detachment, reduced vision in either eye, loss of sight in one eye	☐	☐
Do you wear glasses?	☐	☐
Are you colour blind?	☐	☐
7b. Ear disorders including:	**No**	**Yes**
Ear infections, tinnitus, deafness or vertigo	☐	☐
8a. Cardiac problems including:	**No**	**Yes**
Valve disease, chest pain / angina, heart attack, cardiac arrest, coronary artery disease / bypass, coronary angioplasty / stents, heart rhythm disorders, pacemaker, implanted defibrillator, cardiomyopathy, heart failure, congential heart disorders	☐	☐
8b. Vascular disorders including:	**No**	**Yes**
High blood pressure, varicose veins, arterial claudication, blood clots	☐	☐

	No	Yes
9. Respiratory system disorders including:		
Nose/throat/sinus conditions, bronchitis / emphysema / asthma, collapsed lung, partial or complete lung removal, pulmonary embolism	☐	☐
10a. Dental and mouth health including	**No**	**Yes**
Pain from toothache, dental caries, recurrent mouth and gum infections. Please enter the date of your last dental exam: ……	☐	☐
10b. Digestive disorders including:	**No**	**Yes**
Reflux, peptic ulcers, hernias, enteritis, colitis, Crohn's disease, diverticulitis, ileostomy/colostomy, piles (haemorrhoids), anal fissures or fistulae, liver cirrhosis or failure, bile tract disease including gallstones and jaundice, pancreatitis. Weight loss / gastric surgery.	☐	☐
11a. Urological disorders including:	**No**	**Yes**
Kidney disease / failure, nephritis or nephrosis, kidney or bladder stones, varicocele, epididymitis, enlarged prostate, urine retention, removal of kidney or only one functioning kidney, urine abnormalities	☐	☐
11b. Females: Gynaecological including:	**No**	**Yes**
Heavy vaginal bleeding, menstrual pain, endometriosis, uterine prolapse, fibroids, ovarian cysts	☐	☐
12. Pregnancy:	**No**	**Yes**
Current pregnancy, or delivery / miscarriage / termination in the past 6 weeks	☐	☐
13. Skin including:	**No**	**Yes**
Infections, eczema, dermatitis, psoriasis, other	☐	☐
14. Musculoskeletal including:	**No**	**Yes**
Arthritis, joint disease or replacement, unstable shoulder or knee joints, dislocation, back or neck pain, disc herniation, discitis, amputation or limb prosthesis, radiculopathy, numbness or pins and needles in limbs, restricted mobility. Do you seek regular physical or manual therapy (e.g. osteopathy / chiropractic)?	☐	☐
15. Other	**No**	**Yes**
15a. Speech disorders	☐	☐
15b. Allergies (including anaphylaxis)	☐	☐
15c. Transplants (including kidney, liver, heart, lung)	☐	☐
15d. Blood or blood product transfusion	☐	☐
15e. Current medications (includes non-prescription): list below	☐	☐
15f. Any other medical conditions not mentioned on this form including serious accidents or illnesses, surgeries or hospitalizations	☐	☐

ORIGINAL FORM TO BE PRESENTED TO SHIP'S MEDICAL CENTRE FOR VERIFICATION

PRE-EMPLOYMENT SEAFARER DECLARATION

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First Name:	**Last Name:**

For **ANY YES** answers in sections 1-15, please write details including dates in this section:

Additional questions	**No**	**Yes**	**Details**
Has a medical fitness certificate ever been restricted / revoked?	☐	☐	When? Why?
Have you ever been signed off sick or repatriated from a ship?	☐	☐	When? Why?
Do you smoke or have you ever smoked?	☐	☐	How many per day? When did you quit?
Do you drink alcohol?	☐	☐	How many units per day? Per week?
Do you feel healthy and fit to perform the duties of your designated position / occupation?	☐	☐	

Examination Consent by Seafarer

A full physical examination is required for the medical practitioner to make a comprehensive assessment of fitness for duty at sea. A chaperone can be requested if desired. Please sign below to indicate your consent.

I CONSENT / DO NOT CONSENT to a full physical examination and diagnostic testing (strike through as appropriate)

SEAFARER NAME:	**SEAFARER SIGNATURE:**	**DATE:**

SEAFARER DECLARATION.

My signature below acknowledges that all statements provided by me in this application are true and correct to the best of my knowledge. I authorise and consent to the release of my medical records to my employer from any source, including insurance offices, doctors, hospitals and/or other institutions of public authorities, in line with applicable corporate policies on data protection, especially GDPR policy (01.03.00) and Crew Data Privacy Policy (01.03.10).

I understand that for my own safety, certain pre-existing medical conditions may affect my ability to work at sea and restrictions may apply per international maritime medical standards for seafarers.

I UNDERSTAND THAT FALSIFICATION OF THIS FORM OR WITHOLDING REQUESTED INFORMATION WILL BE GROUNDS FOR LOSS OF BENEFITS AND/OR TERMINATION OF EMPLOYMENT.

SEAFARER NAME:	**SEAFARER SIGNATURE:**	**DATE:**

ORIGINAL FORM TO BE PRESENTED TO SHIP’S MEDICAL CENTRE FOR VERIFICATION