This Seafarer Medical Certificate complies with STCW 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"

RCL EMPLOYMENT MEDICAL EXAMINATION 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: Passenger		Trade Area: Worldwide

DO YOU HAVE, DID YOU EVER HAVE OR HAVE YOU BEEN TOLD YOU HAVE: (to be completed by crew member)

IF YOU ANSWER "Yes" TO ANY OF THE QUESTIONS IN THIS SECTION, PLEASE PROVIDE AN EXPLANATION ON THE NEXT PAGE.
If you do not understand any terms you must ask you medical provider to explain.

	CONDITION	Yes	No
1.	Do you feel healthy and fit to perform the duties of your designated position/occupation? If "No" specify below:	☐	☐
	Explanation:		
2.	Have you ever been declared unfit for sea duty?	☐	☐
3.	Has your medical certificate ever been restricted or revoked?	☐	☐
4.	Have you signed off as sick or repatriated from a ship?	☐	☐
5.	Are you aware that you have any medical problems, diseases, or illnesses?	☐	☐
6.	Do you drink alcohol? How much per day: ____week:___	☐	☐
7.	Do you smoke? How many Years? How much per day?	☐	☐
8.	Have you ever been **Hospitalized**? For What? When?	☐	☐
9.	Have you had **ANY** type of surgery? For What? When?	☐	☐
10.	Have you ever received a blood transfusion? Why?	☐	☐
11.	Are you taking **ANY** medications?	☐	☐
12.	Alternative Medicine or Treatment? What?	☐	☐
	PSYCHIATRIC		
13.	Attempted Suicide?	☐	☐
14.	Ever had thoughts of Harming Self or Others?	☐	☐
15.	Psychiatric Problems / Bipolar / Other Disorders?	☐	☐
16.	Nervous Breakdown / Depression / Anxiety?	☐	☐
17.	Attention deficit/hyperactivity disorder (ADHD)?	☐	☐
18.	Difficulty Concentrating on Things?	☐	☐
19.	Trouble Falling Asleep, Staying Asleep or Sleeping too much?	☐	☐
	ORTHOPEDIC		
20.	Neck Pain/ Scoliosis / Cervical Injury / Radiating Pain?	☐	☐
21.	Back pain / Injury / Sciatica / Radiating Pain?	☐	☐
22.	Hand / Wrist Pain or Numbness?	☐	☐
23.	Elbow Pain / Injury / Surgery?	☐	☐
24.	Shoulder Pain / Injury / Surgery?	☐	☐
25.	Knee Pain / Injury / Surgery / Osteoarthritis?	☐	☐
26.	Feet Pain / Numbness / Tingling / Injury / Surgery / Heel Pain?	☐	☐
27.	Sprains / Dislocations / Fractures?	☐	☐
	INFECTIOUS DISEASES		
28.	Rheumatic Fever (autoimmune)?	☐	☐
29.	Infectious / Contagious Diseases?	☐	☐
30.	Syphilis/HIV/Gonorrhea/Other Sexually Transmitted Disease?	☐	☐
31.	Hepatitis: A ☐ B ☐ C ☐?	☐	☐
32.	Tuberculosis (TB)? Date: ____/____/_____	☐	☐
33.	Yellow Fever / Scarlet Fever / Malaria / Tropical Diseases?	☐	☐
34.	Viral / Mononucleosis / Chicken Pox / Measles / Mumps?	☐	☐

	CONDITION	Yes	No
	CARDIAC		
35.	Chest Pain? Palpitations?	☐	☐
36.	Heart Attack / Irregular Heart Beat / Rate?	☐	☐
37.	Heart Disease?	☐	☐
38.	Heart Surgery / Pacemaker / ICD Implantable (cardiac defibrillator) ?	☐	☐
39.	High Blood Pressure? Date of Diagnosis: ____/____/_____	☐	☐
	ENDOCRINOLOGY		
40.	Diabetes? ☐ Type Unknown ☐ Type I ☐ Type II	☐	☐
41.	Thyroid (weight loss, sweats, tremors) or Other Endocrine Disorders?	☐	☐
	GASTROENTEROLOGY		
42.	Gastritis / Reflux / Gastric or Duodenal Ulcer?	☐	☐
43.	Frequent Diarrhea or Constipation / Straining / Pain?	☐	☐
44.	Bleeding from Stomach or Bowels?	☐	☐
45.	Hemorrhoids / Rectal Bleeding?	☐	☐
46.	Jaundice (Yellow Eyes/Skin) / Gallbladder / Liver Problems	☐	☐
47.	Hernias of Any Kind / Hernia Surgery?	☐	☐
48	Abdominal Pain?	☐	☐
	PULMONARY		
49.	Asthma or Wheezing?	☐	☐
50.	Bronchitis?	☐	☐
51.	Pneumonia?	☐	☐
52.	Coughing Up Blood?	☐	☐
53.	Pulmonary Embolism?	☐	☐
54.	Shortness of Breath?	☐	☐
55.	Sleep Apnea?	☐	☐
	NEUROLOGY		
56.	Headaches / Dizziness / Loss of Consciousness?	☐	☐
57.	Head Injury or Concussion?	☐	☐
58.	Fainting?	☐	☐
59.	Seizures / Epilepsy / Receiving Medications for Either?	☐	☐
60.	Loss of Memory?	☐	☐
61.	Stroke / Mini-Stroke (TIA)?	☐	☐
62.	Muscular Weakness?	☐	☐
	BLOOD DISORDERS		
63.	Anemia / Sickle Cell Anemia?	☐	☐
64.	Hemophilia?	☐	☐
65.	Leukemia?	☐	☐
66.	Other Blood Disorders?	☐	☐
	UROLOGY		
67.	Kidney Problems / Dialysis?	☐	☐
68.	Bladder Infection / Blood in Urine / Kidney Stones?	☐	☐
69.	Prostate Disease (Males)?	☐	☐

	CONDITION	Yes	No
	OPHTHALMOLOGY		
70.	Glaucoma?	☐	☐
71.	Conjunctivitis?	☐	☐
72.	Do you wear glasses / contact lenses?	☐	☐
73.	Eye Injury / Eye or Vision Problems?	☐	☐
74.	Cataracts?	☐	☐
75.	Macular Degeneration History?	☐	☐
76.	Eye Surgery?	☐	☐
77.	Color Blindness?	☐	☐
	EAR, NOSE, & THROAT		
78.	Frequent Ear Infections?	☐	☐
79.	Hearing Loss / Hearing Aids?	☐	☐
80.	Frequent Colds / Sinus Trouble?	☐	☐
81.	Nose Bleed (Adulthood)?	☐	☐
82.	Frequent Sore Throat / Throat Problems or Hoarseness?	☐	☐
83.	Balance Problem / Meniere's Disease / Vertigo / Spinning Sensation?	☐	☐
	DERMATOLOGY		
84.	Skin Problems / Rashes?	☐	☐
85.	Skin Cancer or Tumors?	☐	☐
86.	Dermatitis?	☐	☐
87.	Psoriasis / Eczema?	☐	☐
	RHEUMATOLOGY		
88.	Lupus?	☐	☐
89.	Sarcoid Disease?	☐	☐
90.	Rheumatoid Arthritis?	☐	☐
91.	Joint Pains / Arthritis / Numbness in Extremities?	☐	☐

	CONDITION	Yes	No
	ALLERGIES		
92.	Allergies, Anaphylaxis to Environment, Chemicals, Food/Drugs	☐	☐
	VASCULAR		
93.	Varicose Veins / Varicose vein surgery?	☐	☐
94.	Poor Circulation?	☐	☐
95.	Gout?	☐	☐
	MISCELLANEOUS		
96.	Serious Accidents / Illnesses?	☐	☐
97.	Swollen Glands?	☐	☐
98.	Restricted Mobility?	☐	☐
99.	Implants?	☐	☐
100.	Cancer of any kind (malignant or benign or in remission)?	☐	☐
	GYNECOLOGY		
101.	Are you or do you think you may be pregnant?	☐	☐
102.	What was the date of your last menstrual period? ____/____/_____	☐	☐
103.	Abnormal Vaginal Bleeding?	☐	☐
104.	Gynecological / Female Problems?	☐	☐
105.	Fibroids / Ovarian Cyst?	☐	☐
106.	Frequent Bladder Infections?	☐	☐
107.	Ectopic Pregnancy?	☐	☐
108.	Breast Mass / Lumps /Tenderness? Date of Last Mammogram/Breast Ultrasound: ____/____/_____	☐	☐

CREW MEMBER SECTION **(to be completed by crew member)**

ALL "YES" RESPONSES ABOVE REQUIRE COMMENTS (IN ENGLISH) FROM THE CREW MEMBER AND MUST BE REVIEWED BY PHYSICIAN

Question #:	Comments:

Crew Member Section Reviewed and initialed by Physician: _____

PHYSICIAN SECTION: TO BE COMPLETED BY PHYSICIAN

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

Question #:	Comments:

CERTIFICATION

By signing below I hereby certify that the information contained in this form is true, correct, and complete to the best of my knowledge and belief. **I understand that any false information, misrepresentation, or omission of facts in this form are grounds for loss of benefits (including without limitation, medical benefits, sick pay, maintenance, death benefits, and disability benefits), disqualification from further consideration, and/or immediate termination of employment without recourse.**

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

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I understand the purpose of this examination is for Royal Caribbean Cruises Ltd. and/or its affiliates ("RCL")

- To obtain information that may be used to determine fitness for duty and/or
- To comply with legal or other reporting obligations, and/or
- To investigate or evaluate any alleged or reported injury, loss, damage, crime and its or their causes or circumstances, and/or
- To assert or defend against legal claims.

To achieve the above purposes, I hereby request and authorize RCL to release all my medical records and information from any source, including without limitation, hospitals, clinics, labs, physicians, psychologists, employers, insurance companies, government authorities, and any other health professionals, health institutions, or public authorities (collectively, "Medical Records')to any RCL medical personnel, any third party performing medical record review, quality control entities, and any other person or entity necessary for RCL to determine or verify whether I am fit for duty.

In the event I make a claim for medical benefits, sick pay, death, or disability benefits, or any other benefits, I further authorize RCL to release all my Medical Records to RCL personnel to make a claim determination or resolve a claim dispute or appeal. I authorize the release of all my Medical Records to the physician(s) performing the medical examination subject of this form.

I authorize release of my Medical Records to any government authority such as the F.B.I. the U.S. Coast Guard, the Centers for Disease Control (CDC) or any other national, state or local authority either in the U.S> or abroad, or any other person or entity as may be required by law.

I hereby authorize the release of my Medical Records, including patient history, office notes, test results, radiology studies, films, referrals, consultants and billing records, even if said record(s) include information related to alcohol, drug abuse, mental health treatment, or confidential HIV related information, to me and/or my health insurer or any other entity from which I requested third party payment for the services provided at this medical facility.

Further, I acknowledge that my Medical Data might be transferred to countries outside the European Union (EU) and/or the European Economic Area (EEA). When we transfer your Medical Data outside the EU/EEA, the laws and rules that protect your Medical Data in such countries may be different (or less protective) from your own country. For example, the circumstances in which law enforcement can access your Medical Data may vary from country to country.

Your consent declaration is completely voluntary and you may as well revoke it at any time. The withholding or revocation of your consent will not have any negative, especially no disciplinary, consequences. However, RCL might not be able to assign you to certain tasks that require an approved level of fitness if you withhold or withdraw your consent. If you revoke your consent, this will not impact the legitimacy of the previous use of your data that was based on your initial declaration of consent. You may revoke your consent by email to privacy@rccl.com. If there is another legal basis for processing, RCL reserves the right to process the data on such other legal basis.

This authorization is executed in compliance with the Heath and Insurance Portability and Accountability Act (HIPAA) of 1996 and 45 C.F.R. Parts 160 and 164.

You can find all further information on the processing of your Personal Data including your rights to access, rectification and erasure of your data, and contact details for a revocation of your consent in the most recent version of our employee privacy notice available at: http://www.royalcaribbean.com/privacypolicy.

My signature below signifies that, to the best of my knowledge and belief, all information, answers and responses provided to the company, or company affiliated physicians, labs or medical staff, are true and correct. I fully understand that I have an ongoing obligation to fully disclose any and all medical conditions which may affect my employment, whether listed above or not. I also agree to continuously update Royal Caribbean Cruises Ltd. or its affiliated brands with any and all medical information which arise subsequent to the date of this document. I fully understand that if I falsify or withhold relevant medical information or condition(s) and/or fail to provide Royal Caribbean Cruises Ltd. or affiliated brands with updated information as necessary subsequent to the date of this document, such action or inaction WILL SERVE AS GROUNDS FOR TERMINATION OF MY EMPLOYMENT WITHOUT EMPLOYMENT BENEFITS AND/OR MAINTENANCE OR CURE BENEFITS. I ALSO AUTHORIZE RELEASE OF ANY / ALL MEDICAL INFORMATION CONCERNING MY PAST, PRESENT OR FUTURE MEDICAL CONDITION(S), BY ANY MEDICAL PRACTITIONER OR PROVIDER, TO ROYAL CARIBBEAN CRUISES LTD. OR ITS AUTHORIZED REPRESENTATIVE. I AM ABLE TO READ, WRITE AND SPEAK ENGLISH AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION.

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

ACKNOWLEDGMENT BY PHYSICIAN

I acknowledge that I have reviewed the information contained in this form with the Applicant and noted Comments as required.

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

RCL PRE-EMPLOYMENT MEDICAL EXAMINATION 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	Passport No.:		Nationality:
City of Residence:	Country of Residence:	Vessel:	Type of Ship: Passenger		Trade Area: Worldwide

GENERAL

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

Body Mass Index (BMI) – Maximum is 35 _____ HbA1C _____

B/P Systolic _____ B/P Diastolic _____ Repeat BP Test on a different day if result is **140/90 or greater** B/P Systolic _____ B/P Diastolic _____

VISION

Visual Acuity							Color Vision			
Vision	Unaided			Aided			☐ Ishihara	☐ Not Tested	☐ Passed	☐ Failed
	Right Eye	Left Eye	Binocular	Right Eye	Left Eye	Binocular	☐ Snellen	☐ Not Tested	☐ Passed	☐ Failed
Distant							☐ Bostrom Kugelberg	☐ Not Tested	☐ Passed	☐ Failed
Near							**Field Vision**	R = WNL _____	L = WNL _____	

Vision adequate for position per Flag State Requirements? ☐ Yes ☐ No

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

☐ **Normal** ☐ **Abnormal**

Performed on (Day/Month/Year):

(EKG REQUIRED IF HISTORY OF HYPERTENSION)

Results: (including EKG, if applicable)

VACCINATIONS PROVIDE COPY OF VACCINATION RECORD

REQUIRED TESTS

MMR	Last Vaccination Date
MANDATORY	

CRITICAL VALUES

BP:	
GLUCOSE:	
HbA1C:	
CREATININE:	
BMI:	

Reviewed and Initialed by Physician: _____

✓	ATTACH ALL LAB TESTS - ALL RESULTS MUST BE IN ENGLISH
☐	Chest X-ray (Attach Report)
☐	VDRL/RPR/FTA (Use One)
☐	CBC (Complete Blood Count)
☐	HbA1C (If serum OR fasting glucose are elevated OR history of Diabetes)
☐	Routine Urinalysis
☐	Thyroid Studies (If history of thyroid issues)
☐	O&P (Food and Beverage Positions)
☐	Hepatitis A IgM, HBsAg and Anti HCV
☐	HIV* (If Positive, also CD4/Viral Load) Date of positive: ____/____/_____
☐	Urine Drug Test (Benzodiazepines, Amphetamines, THC, Opiates, Cocaine)
☐	Blood Chemistry - BUN, Creatinine, Glucose, ALT, AST, Uric Acid
☐	Lipid Panel total Chol, HDL, LDL, Triglycerides
☐	EKG Original 12 Lead EKG Provided to CM (Required ONLY If There's a History of High Blood Pressure)
☐	GFR if history of diabetes or hypertension
☐	**Abnormal Results Requiring Investigation**

**Where permitted by local law*

PHYSICAL EXAM

HEENT	Normal	Abnormal
Mouth / Teeth		
Tonsils		
Pharynx		
Ears/Tympanic Membrane		
Eyes/Eye Movement/Pupils		
Head		
Nose		
Nodes	NIL	
Motion		
Thyroid		
Scars		
EMOTIONAL / PSYCHIATRIC	**Normal**	**Abnormal**
Status		
HEART	**Normal**	**Abnormal**
Rhythm		
Murmurs	NIL	

THORAX LUNGS	Normal	Abnormal
Percussion		
Auscultation		
NEURO	**Normal**	**Abnormal**
Motor		
Sensory		
Reflexes		
SKIN	**Normal**	**Abnormal**
Skin		
PULSES	**Normal**	**Abnormal**
Pulse		
EXTREMITIES	**Normal**	**Abnormal**
Varicose Veins (Indicate CEAP Level)	NIL	
Edema	NIL	
Scars		
Discoloration	NIL	
Deformities	NIL	

ABDOMEN	Normal	Abnormal
Shape		
Tenderness	NIL	
Masses	NIL	
Scars		
Hernia	NIL	
Testicles		

RECTAL	Normal	Abnormal
Hemorrhoids	NIL	
Prostate		
Fistula	NIL	
BREASTS	**Normal**	**Abnormal**
Tenderness	NIL	
Masses	NIL	

RANGE OF MOTION

CERVICAL	Normal	Abnormal
Forward Flex		
Extension		
Lateral Flexion		
Rotation		
Scars		
HIP		
Flexion		
Extension		
Abduction		
Adduction		
Int. Rotation		
Ext. Rotation		
FINGERS		
Flexion		
Extension		

ELBOW	Normal	Abnormal
Retained Flex		
Extension		
Pronation		
Supination		
Scars		
FEET		
Inspection		
Arch Status		
Deformities		
ANKLE		
Dorsal Flex		
Plantar Flex		
Inversion		
Eversion		
Scars		

LUMBAR	Normal	Abnormal
Forward Flex		
Extension		
Lat. Flex		
Rotation		
SLR (Sitting)		
SLR (Supine)		
Scars		
SHOULDER		
Forward Elev.		
Backward Elev.		
Abduction		
Adduction		
Int. Rotation		
Ext. Rotation		
Scars		

WRIST	Normal	Abnormal
Pronation		
Supination		
Dorsiflexion		
Plantar Flexion		
Abduct		
Adduct		
KNEE		
Retained Flex		
Extension		
Scars		

Applicant questioned regarding current or previous psychiatric condition/diagnosis? ☐ Yes ☐ Applicant Denied
If applicant's answer is "Yes" please describe on the next page.

Applicant questioned regarding current or previous back/lumbar condition/diagnosis? ☐ Yes ☐ Applicant Denied
If applicant's answer is "Yes" please describe on the next page.

Consultation or Referral Reports Attached: ☐ Yes ☐ No

Psychiatric and/or back conditions require medical clearance letter from specialist

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):

☐ **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

RCL MEDICAL CERTIFICATE FOR SERVICE AT SEA

This Medical Certificate has been issued in accordance with 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 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 ☐NA ☐Fit for look-out duty		
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 of Malta and the Bahamas.*

*** 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.*