

APPLICATION FORM FOR MEDICAL EXAMINATION

SURNAME	FIRST NAME	MIDDLE NAME (S)	SEX	AGE	WEIGHT	GRADE OF THE OFFICER
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**MEDICAL HISTORY: DO ANY OF THE MEDICAL CONDITIONS LISTED APPLY?
INDICATE ADDITIONAL COMMENTS BELOW (33).**

	YES	NO		YES	NO		YES	NO
1. LOSS OF VISION	<input type="checkbox"/>	<input type="checkbox"/>	6. HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	11. EPILEPSY OF ATTACKS	<input type="checkbox"/>	<input type="checkbox"/>
2. COLOR BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>	7. CHEST PAINS	<input type="checkbox"/>	<input type="checkbox"/>	12. KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
3. SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	8. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	13. VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
4. FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	9. SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	14. NARCOTICS HISTORY	<input type="checkbox"/>	<input type="checkbox"/>
5. HEART DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	10. TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	15. OTHER ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>

CLINICAL EVALUATION

NOTES: DESCRIBE EVERY ABNORMALITY AND ENTER PERTINENT ITEM NUMBER BEFORE EACH COMMENT (33)

	NORMAL YES	NO		NORMAL YES	NO
16. HEAD, FACE, NECK, SCRIP	<input type="checkbox"/>	<input type="checkbox"/>	20. GENITO - URINARY (HEMATURIAL, PYURIA)	<input type="checkbox"/>	<input type="checkbox"/>
17. CHEST AND LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	21. RECTUM (BLOOD, MASSES)	<input type="checkbox"/>	<input type="checkbox"/>
18. VASCULAR SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	22. LOWER EXTREMITIES (VARICOSITIES)	<input type="checkbox"/>	<input type="checkbox"/>
19. ABDOMEN AND VISCERA	<input type="checkbox"/>	<input type="checkbox"/>	23. APPEARANCE & MENTAL STATE	<input type="checkbox"/>	<input type="checkbox"/>

24. VISION		25. COLOR PERCEPTION	26. HEARING
RIGHT EYE LEFT EYE BOTH EYES	UNCORRECTED 20/ 20/ 20/ CORRECTED 20/ 20/ 20/	BOOK <input type="checkbox"/> LANTERN <input type="checkbox"/> YELLOW _____ RED _____ GREEN _____ BLUE _____	RIGHT EAR _____ LEFT EAR _____

27. BLOOD PRESSURE SYSTOLIC _____ DIASTOLIC _____	28. RESPIRATION / MIN.	28. PULSE RATE _____ REGULAR <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
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LABORATORY FINDING

30. CHEST RADIOGRAPHY REPORT:	ALBUMIN	SUGAR	32. VDRL: POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/>
31. URINALISIS: SPECIFIC GRAVITY			

(a) APPLICANTS WHO HAVE A MEDICAL HISTORY OF PAST OR PRESENT EPILEPSY, ACUTE VENERAL DISEASE, NEUROSYPHILIS, VARICOSE VEINS OR USE OF NARCOTICS OR OTHER DISEASES ACCORDING TO MEDICAL CRITERIA WILL BE DISQUALIFIED.

(b) CLINICAL EVALUATION:
b. 1. VISION REQUIREMENTS FOR:

	DECK OFFICERS	ENGINEER OFFICERS	RADIO OFFICERS
COLOR	PERFECT COLOR PERCEPTION	ABLE TO PERCEIVE RED, YELLOW AND GREEN	
UNCORRECTED BOTH EYES, AT LEAST	20/100	20/100	20/100
CORRECTED ONE EYE, AT LEAST	20/20	20/30	20/30
CORRECTED OTHER EYE, AT LEAST	20/40	20/50	20/50

b. 2. SEVERELY IMPAIRED HEARING WILL DISQUALIFY THE APPLICANT.
b. 3. TAKING AGE INTO CONSIDERATION, THE APPLICANTS MUST HAVE NORMAL BLOOD PRESSURE, AND GOOD GENERAL PHYSICAL CONDITION AS FOUND IN THE CLINICAL EVALUATION.

(c) LABORATORY FINDINGS:
THE LABORATORY FINDINGS MUST CONFIRM SATISFACTORY GENERAL PHYSICAL CONDITIONS.

33. COMMENTS ON MEDICAL HISTORY AND CLINICAL EVALUATION

REMARKS, ACCORDING TO MEDICAL REQUIREMENTS, SUMMARIZE BELOW ANY MEDICAL FINDINGS WHICH, IN YOUR OPINION, WOULD LIMIT THIS PERSON'S PERFORMANCE OF THE JOB DUTIES AND/OR WOULD MAKE HIM A HAZARD TO HIMSELF OR OTHERS. CHECK THE LIMITING MEDICAL CONDITION, AND LIST THE DISQUALIFYING DEFECT BY ITEM NUMBER.

(a) (b) (c) DEFECT BY ITEM NUMBER _____

NAME OF EXAMINING PHYSICIAN	ADDRESS OF THE MEDICAL CENTER		
NAME OF MEDICAL CENTER	LICENSE No.		
TELEPHONE	TELEX:		
DATE			
	D	M	Y

IS THE APPLICANT PHYSICALLY QUALIFIED ACCORDING TO THE MEDICAL REQUIREMENTS? SI NO

DATE _____ SIGNATURE AND SEAL OF EXAMINING PHYSICIAN _____

IMPORTANT NOTICE:
THIS APPLICATION FORM SHALL NOT BE CONSIDERED VALID FOR THE INSURANCE OF A CERTIFICATE OF COMPETENCY EXAMINATION CONFIRMATION FOR MERCHANT MARINE SEAFARERS ABOARD PANAMANIAN VESSELS, IF IT DOES NOT COMPLY WITH ANY OF THE FOLLOWING REQUIREMENTS:
1. THE LACK OF ADDRESS, TELEPHONE NUMBER, STAMP AND/OR SIGNATURE OF THE PHYSICIAN.
2. INCORRECTLY FILLED OUT OR THE LACK OF ANY OF THE LABORATORY TESTS INDICATED IN THE FORM.
3. STCW95, Regulation I/9 - Medical Standards - Issue and Registration of Certificates, and Section B-1/9 Paragraph 11 "Notwithstanding these provisions, the Administration may require higher standards than those given in table B-1/9-1 or table B-1/9-2 below"
4. ILO/WHO/A.2/1997 - Guidelines for the medical fitness review of seafarers previous to embarkment and periodics, of the International Labor Organization (ILO) and the World Health Organization (WHO)
This form demands the minimum medical fitness conditions that sailors must fulfil.