Republic of Seychelles
Seafarer Medical Certificate for service at sea

Recent Photo

Certificate No._____

This certificate is issued by the Government of the Republic of Seychelles in compliance with the requirements of Article 2 (a)(iii) of the Merchant ships (Minimum Standards) Convention 1976 (ILO No. 147 & No. 73), the International Convention on standards of Training Certification and Watchkeeping for Seafarers (STCW) , 1978 as amended and the Maritime Labour Convention, 2006.

Full Name (family name , given name	
Date of Birth(dd/mm/yyyy)	
Gender	
Nationality	
Department (deck, engine, catering)	

Declaration of approved medical practitioner	Yes	No	NA
Confirmation that identification documents were checked at the point of examination?			
Hearing satisfactory and meets the standards in STCW Code , Section A-I/9			
Unaided hearing satisfactory?			
Visual acuity satisfactory and meets standards in STCW Code , section A-I/9 and MLC 2006 1.2-6(a)?			
Color vision satisfactory and meets standards in STCW Code , section A-I/9 and MLC 2006 1.2 6(a)?			
Date of last color vision test			

I have evaluated the above-named according to National Law and International Conventions & Guidelines: MLC 2006, STCW 95 and Guidelines ILO/WHOD/D.2/2013.

On the basis of the examinee's personal declaration, my clinical examination and diagnostic test results recorded on the Medical Examination Form (appended to this certificate), I certify that the seafarer concerned is not suffering from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board and hence declare the examinee medically:

☐ **Fit for look-out duties** ☐ **Not fit for look-out duties**

	Deck service	Engine service	catering service	other service
Fit				
Unfit				

☐ without restrictions ☐ with restrictions

Visual aid required ☐ yes ☐ No
Chest X-ray ☐ normal ☐ not performed
Bacteriological stool test ☐ negative ☐ not performed
Parasitical stool test ☐ negative ☐ not performed
Vaccination records ☐ negative ☐ not performed

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

Place of examination _____ Date(dd/mm/yyyy) ___/____/_____
Medical certificate's date of expiration(dd/mm/yyyy) ___/____/_____
Name and stamp of medical examiner:_____
Signature of medical examiner :_____

Authorized by : _____(competent authority)

Seafarer Acknowledgement

I acknowledge and confirm that I have been nformed of the content of the certificate and of the right to a review in accordance with paragraph of section A-I/ of STCW Code.

Examinee's Signature: _____
(to be signed in the presence of the medical examiner)

Republic of Seychelles
Seafarer Medical examination form
(Confidential form)

Serial No. _____

Pre- Sea Periodic

Full Name(Surname, Given Name(s)	
Date of Birth(dd/mm/yyyy	
Gender	
Nationality	
Home address	
Passport No./ CDC No.	
Type of ship(Container, tanker , passenger, fishing)	
Trading area(Coastal, tropical, worldwide)	
Department (Deck, Engine, catering)	

A. Examinee's Personal Declaration

Have you ever had any of the following conditions?

Condition	Yes	No	Condition	Ye	No
1. Eye or vision problem	☐	☐	19. Sleeping problems	☐	☐
2. High blood pressure	☐	☐	20. Do you smoke/ use Alcohol or drug?	☐	☐
3. Heart/vascular disease	☐	☐	21. Back or joint problems	☐	☐
4. Heart surgery	☐	☐	22. Operation/surgery	☐	☐
5. Varicose veins	☐	☐	23. Epilepsy/seizures	☐	☐
6. Asthma/bronchitis	☐	☐	24. Dizziness/fainting	☐	☐
7. Blood Disorder	☐	☐	25. Loss of consciousness	☐	☐
8. Diabetes	☐	☐	26. Psychiatric problems	☐	☐
9. Thyroid problem	☐	☐	27. Amputation	☐	☐
10. Digestive disorder	☐	☐	28. Depression	☐	☐
11. Kidney problem	☐	☐	29. Attempted suicide	☐	☐
12. Skin problem	☐	☐	30. Loss of memory	☐	☐
13. Allergies	☐	☐	31. Balance problem	☐	☐
14. Infectious/contagious diseases	☐	☐	32. Severe headache	☐	☐
15. Hernia	☐	☐	33. Ear/nose/throat problems	☐	☐
16. Genital disorders	☐	☐	34. Restricted mobility	☐	☐
17. Pregnancy	☐	☐	35. Fractures/dislocations	☐	☐
18. Tuberculosis	☐	☐			

Additional questions

36. Have you ever been signed off as sick or repatriated from a ship?..... ☐ ☐
37. Have you ever been hospitalized?..... ☐ ☐
38. Have you ever been declared unfit for sea duty?..... ☐ ☐
39. Has your medical certificate ever been restricted or revoked?.....
40. Are you aware that you have any medical problems, diseases or illnesses?..... ☐ ☐
41. Do you feel healthy and fit to perform the duties of your designated position/occupation? ..... ☐ ☐
42. Are you allergic to any medications? ☐ ☐
43. Are you taking any non- prescription or prescription medications? ☐ ☐

If yes, please list the medications taken and the purpose (s) and dosage(s)

If any of the above questions were answered "yes", please give details.

_____

_____

I _____holding passport/ CDC No. _____ hereby declares that I have made full disclosure of all my medical history to the doctors and staff of this clinic.

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. (the approved medical practitioner carrying out the medical examinations).

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

Signature of examinee: _____ Date (day/month/year): _____/_____ /_____

Witnessed by: *(Signature)* _____ Name: *(Typed or printed)*_____

B. Medical examination

Pre-sea Periodic Other

Sight

use of glasses or contact lenses : Yes No (if yes , specify which type and for what purpose)

	Visual acuity					
	Unaided			Aided		
	Right eye	Left eye	binocular	Right eye	Left eye	Binocular
Distant						
Near						

	Visual fields	
	Normal	Defective
Right eye		
Left eye		

Colour vision: Not tested Normal Doubtful Defective

Colour vision meets standards in STCW Code (section A-I/9) Yes/No

Testing is only required every six years. Date tested: ……..….

Speech and whisper test (metres)

Hearing

Pure tone and audio metry (threshold values in dB)

	500 Hz	4,000 Hz	2,000 Hz	3,000 Hz	4,000 Hz	6,000 Hz			Normal	Whisper
Right ear								Right ear		
Left ear								Left ear		

Height: _____(cm) Weight: _____(kg)

Pulse rate: _____(/(minute) Rhythm: _____

Blood pressure: Systolic: _____(mm Hg) Diastolic: _____(mm Hg)

Urinalysis: Glucose: _____ Protein: _____

	Normal	**Abnormal**		**Normal**	**Abnormal**
Head			Varicose veins		
Sinuses, nose, throat			Vascular (inc. pedal pulses)		
Mouth/teeth			Abdomen and viscera		
Ears (general)			Hernia		
Tympanic membrane			Anus (not rectal exam.)		
Eyes			G-U system		
Opthalmoscopy			Upper and lower extremities		
Pupils			Spine (C/S, T/S and L/S)		
Eye movement			Neurologic (full brief)		
Lungs and chest			Psychiatric		
Breast examination			General appearance		
Heart					
Skin					

Chest X-ray: Not performed Performed on (day/month/year): _____/_____/_____

Results: _____

EGC: Not performed Performed on (day/month/year): _____/_____/_____

Results: _____

Other diagnostic test(s) and result(s)

Test	Result	
Blood tests – tick in box if done- readings separately issued *[1]	☐ CBC ☐ Blood VDRL test ☐ ESR ☐ Blood Sugar - Random	
Hemoglobin ' Hb' * [1]		
Hepatitis B*[3]	HB (ab) ☐ +ve -v☐	HB (ag) +ve -ve
Bacteriological stool test *[4]	☐ Performed ☐ negative ☐ positive	
Parasitical stool test *[5]	☐ not performed ☐ negative ☐ positive	
ECG (only for crew above 40 years)		
HIV *[2] +ve or -ve		

*[1] compulsory *[3] required by the company for all crew members *[5] required by company for all food handlers from tropical climates

*$_2$ not compulsory *$_4$ required by company for all food handlers

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 look-out duty		Not fit for look-out duty		
	Deck service	Engine service	Catering service	Other services
Fit				
Unfit				

Without restrictions With restrictions

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

Action taken by medical examiner (e.g., referral):

Place of examination: _____ Date of examination (day/month/year):_____/_____ /_____

Medical certificate's date of expiration (day/month/year):_____/_____ /_____

Official stamp (also print name of medical examiner if not legible):

Signature of medical examiner: _____

Medical practitioner information (name , license no. , address)

Authorized by: _____ (competent authority)