Human Environment and Transport
Inspectorate
*Ministry of Infrastructure*
*and Water Management*

# Medical examination
## Shipping crew

Contact the medical examiner for more information about this form.

**More information**
+31(0) 88 489 00 00 | www.ilent.nl

## 1 Details seafarer

| | | |
|---|---|---|
| 1.1 | Surname and Gender | ☐ Male ☐ Female |
| 1.2 | First names in full | |
| 1.3 | Date of birth and place of birth | |
| 1.4 | Nationality | |
| 1.5 | Address | |
| 1.6 | Postcode and city | |
| 1.7 | Telephonenumber(s) | |
| 1.8 | Number seaman's book and country of issue | NOT MANDATORY |
| 1.9 | Number of ID or passport | |

## 2 Details of family doctor/G.P.

| | | |
|---|---|---|
| 2.1 | Name | |
| 2.2 | Address | |

## 3 Details work/education

| | | |
|---|---|---|
| 3.1 | Name ship owner / nautical college | |
| 3.2 | Type of ship | |
| 3.3 | Duties on board the ship | |
| 3.4 | Sailing area | |

# Medical examination



## 4 Details of previous examinations

| | | | |
|---|---|---|---|
| 4.1 | Have you ever been declared unfit for duty? | ☐ Yes | ☐ No |
| 4.2 | Have you ever been declared fit with restrictions? | ☐ Yes | ☐ No |
| 4.3 | Have you ever had a medical exemption? | ☐ Yes | ☐ No |
| 4.4 | Date of the last medical examination | | |
| 4.5 | Details | | |

## 5 Details present examination

| | | |
|---|---|---|
| 5.1 | Your examination concerns | ☐ Seafarer with look-out or watch duties on the bridge |
| | | ☐ Seafarer with watch duties in the engine room |
| | | ☐ Seafarer without look-out or watch duties, but with safety and/or security duties |
| | | ☐ Seafarer without safety and/or security duties |

## 6 Medical questions

| | | | | | |
|---|---|---|---|---|---|
| 6.1 | Do you experience any limitations in the performance of your duties? | ☐ Yes | ☐ No | | |
| 6.2 | Have you ever been repatriated due to illness? | ☐ Yes | ☐ No | | |
| 6.3 | Have you ever had an accident? | ☐ Yes | ☐ No | | |
| 6.4 | Have you ever had surgery? | ☐ Yes | ☐ No | | |
| 6.5 | Can you use both hands unrestricted in range of motion and sensibility? | ☐ Yes | ☐ No | | |
| 6.6 | Have you suffered from any occupational disease? | ☐ Yes | ☐ No | | |
| 6.7 | Are you allergic to any substance? | ☐ Yes | ☐ No | | |
| 6.8 | Are you night blind? | ☐ Yes | ☐ No | | |
| 6.9 | Do you wear glasses or contact lenses? | ☐ Yes | ☐ No | | |
| 6.10 | Is your colour vision normal? | ☐ Yes | ☐ No | | |
| 6.11 | Have you had eye surgery or laser treatment? | ☐ Yes | ☐ No | | |
| 6.12 | Do you use a hearing-aid? | ☐ Yes | ☐ No | | |
| 6.13 | Do you take any medication? If so, which? | ☐ Yes | ☐ No | | |
| 6.14 | Do you drink alcohol? If so, how many units per week? | ☐ Yes | ☐ No | | a week |
| 6.15 | Do you smoke? If so, how many per day? | ☐ Yes | ☐ No | | a day |
| 6.16 | Did you use illegal drugs during the past 5 years? | ☐ Yes | ☐ No | | |
| 6.17 | Are you pregnant? Expected date of delivery? | ☐ Yes | ☐ No | ☐ N.a. | |
| 6.18 | Do you have painful or irregular periods? | ☐ yes | ☐ No | ☐ N.a. | |
| 6.19 | When was your last visit to the dentist? | | | | |
| 6.20 | Can you turn a rescue raft? (STCW-training) | | | | |
| 6.21 | Are you able to wear a breathing apparatus? (STCW-training) | | | | |

6.22 Details

## 7 Physical complaints

7.1 Do or did you suffer from any of the following?

| | | |
|---|---|---|
| Diabetes | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Thyroid disorders | ☐ Yes | ☐ No |
| Contagious diseases, tropical diseases | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |
| Trombosis or embolism | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Epilepsy, seizures or convulsions | ☐ Yes | ☐ No |
| Psychological problems | ☐ Yes | ☐ No |
| Alcohol dependency | ☐ Yes | ☐ No |
| Nervous strain, depression | ☐ Yes | ☐ No |
| Fear of heights / open spaces / claustrophobia | ☐ Yes | ☐ No |
| Insomnia | ☐ Yes | ☐ No |
| Sleep-walking, bed-wetting | ☐ Yes | ☐ No |
| Skin diseases, eczema | ☐ Yes | ☐ No |
| Venereal diseases | ☐ Yes | ☐ No |
| Inguinal hernia | ☐ Yes | ☐ No |
| Varicose veins, haemorrhoids | ☐ Yes | ☐ No |
| Headache, dizziness | ☐ Yes | ☐ No |
| Syncope, fainting | ☐ Yes | ☐ No |
| Low vision or blurred vision | ☐ Yes | ☐ No |
| Poor hearing or ringing in the ear | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Coughing, shortness of breath | ☐ Yes | ☐ No |
| Asthma, bronchitis | ☐ Yes | ☐ No |
| Hypertension | ☐ Yes | ☐ No |
| Heart diseases | ☐ Yes | ☐ No |
| Chest pain, palpitations | ☐ Yes | ☐ No |
| Swollen feet, especially in the evening | ☐ Yes | ☐ No |
| Stomach-ache, nausea, low appetite | ☐ Yes | ☐ No |
| Abdominal pain, cramps | ☐ Yes | ☐ No |
| Black or discoloured stools | ☐ Yes | ☐ No |
| Strain or pain during urinating | ☐ Yes | ☐ No |
| Pain in the back | ☐ Yes | ☐ No |
| Painful arms, legs or joints | ☐ Yes | ☐ No |
| Fractures, dislocations | ☐ Yes | ☐ No |
| Seasickness | ☐ Yes | ☐ No |

7.2 Details

## 8 Signature

The undersigned is aware of the fact that due to false or inaccurate completion of this medical history the medical examination may be considered invalid. The undersigned therefore certifies that the personal declaration above is a true statement to the best of his or her knowledge.

8.1 Place and date

8.2 Signature

## 9 Details examination and medical examiner

| | | |
|---|---|---|
| 9.1 | Date of examination | |
| 9.2 | Name medical examiner | |

## 10 Physical examination

| | | |
|---|---|---|
| 10.1 | Length and body weight | |
| 10.2 | BMI | |
| 10.3 | Waist circumference (optional) | |
| 10.4 | Pulse and blood pressure | |
| 10.5 | General physical appearance | |
| 10.6 | Mental state | |
| 10.7 | Skin | |
| 10.8 | Lymph nodes | |
| 10.9 | Neck / thyroid | |
| 10.10 | Mouth / throat / nose | |
| 10.11 | Dental status | |
| 10.12 | Speech | |
| 10.13 | Heart | |
| 10.14 | Lungs | |
| 10.15 | Abdomen | |
| 10.16 | Genitals, groins | |
| 10.17 | Upper extremities | |
| 10.18 | Lower extremities | |
| 10.19 | Spine | |
| 10.20 | Motor system | |
| 10.21 | Co-ordination | |
| 10.22 | Reflexes | |

## 11 Fitness and physical abilities

| | | | |
|---|---|---|---|
| 11.1 | Climb up and down vertical ladders | ☐ Sufficient | ☐ Inadequate |
| 11.2 | Step over coamings (60cm) | ☐ Sufficient | ☐ Inadequate |
| 11.3 | Grasp, lift, manipulations | ☐ Sufficient | ☐ Inadequate |
| 11.4 | Reach above shoulder height | ☐ Sufficient | ☐ Inadequate |
| 11.5 | Stoop, crouch, kneel and crew | ☐ Sufficient | ☐ Inadequate |
| 11.6 | Stand and walk a watch for extended periods | ☐ Sufficient | ☐ Inadequate |
| 11.7 | Fit through a restricted opening of 60x60 cm | ☐ Sufficient | ☐ Inadequate |

## 12 Vision / eyes

| | | | | |
|---|---|---|---|---|
| 12.1 | Visual acuity, unaided | OD | OS | ODS |
| 12.2 | Visual acuity, aided | OD | OS | ODS |
| 12.3 | Near vision, aided | | | ODS |
| 12.4 | Reading a computer at a distance of 70 cm | | | ODS |
| 12.5 | Visual fields | OD | OS | |
| 12.6 | External inspection | OD | OS | |
| 12.7 | Eye movements | OD | OS | |
| 12.8 | Pupillary light reflex | OD | OS | |
| 12.9 | Signs of double vision | ☐ Yes | ☐ No | |
| 12.10 | Spare glasses | ☐ Yes | ☐ No | |

**Colour vision**

| | | | |
|---|---|---|---|
| 12.11 | Ishihara 2 or more mistakes | ☐ No | ☐ Yes (detailed examination required) |
| 12.12 | Specialist colour test | ☐ Sufficient | ☐ Defective |
| 12.13 | Specialist colour test used, plus results | | |

**More detailed examination required**

| | | | |
|---|---|---|---|
| 12.14 | Night-blindness | ☐ Yes | ☐ No |
| 12.15 | Opthalmoscopy | ☐ Yes | ☐ No |

## 13 Hearing/ ears

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13.1 | Conversational speech | AD | m | AS | m |
| 13.2 | Tone-audiometric loss 500 Hz. | AD | dB | AS | dB |
| 13.3 | Tone-audiometric loss 1000 Hz. | AD | dB | AS | dB |
| 13.4 | Tone-audiometric loss 2000 Hz. | AD | dB | AS | dB |
| 13.5 | Tone-audiometric loss 3000 Hz. | AD | dB | AS | dB |
| 13.6 | Tone-audiometric loss average | AD | dB | AS | dB |
| 13.7 | Otoscopy | AD | | | |
| | | AS | | | |

## 14 Diagnostic tests

| | | |
|---|---|---|
| 14.1 | Does the candidate come from an area with a high prevalence of tuberculosis? | ☐ Yes (Examination on tuberculosis indicated) |
| | | ☐ No |
| 14.2 | Chest X-ray / Mantoux date, plus results | |
| 14.3 | Urine: | |
| | Protein | |
| | Glucose | |
| | Blood | |

## 15 Additional diagnostic tests

15.1 Remarks

## 16 Specialist report

16.1 Remarks

## 17 Family history

17.1 Remarks

## 18 Consultation with attending physician

18.1 Remarks

## 19 Comments, notes

19.1 Remarks

## 20 Validation exemptions

20.1 The exemptions given by the medical advisor are valid until?

Exemption with regard to general medical fitness:

Exemption with regard to the visual system:

Exemption with regard to the auditory system:

## 21 Conclusion seafarer's examination

21.1

| Complies to the medical standards of | Look-out or watch duties on the bridge | | | Watch duties in the engine room | | | Without look-out or watch duties, but with safety and/or security duties | | | Without look-out, watch, safety or security duties | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Yes* | *Exemption** | *No* | *Yes* | *Exemption ** | *No* | *Yes* | *Exemption ** | *No* | *Yes* | *Exemption ** | *No* |
| *Medical fitness* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Visual system* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Auditory system* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *CONCLUSION* | ☐ *Fit for duty ** | ☐ *Unfit ***| | ☐ *Fit for duty ** | ☐ *Unfit ***| | ☐ *Fit for duty ** | ☐ *Unfit ***| | ☐ *Fit for duty ** | ☐ *Unfit ***| |

* *The expiry date of the Seafarer medical certificate may never exceed the expiry date on the exemption.*
** *A candidate is unfit if "No" is ticked once, unless the candidate holds a valid exemption.*

21.2 Restrictions to area of validity

21.3 Restrictions to period of validity

## Health declaration

**Valid up to two years after date of issue**

| **Employee's details** | | | | | | Explanatory note |
|---|---|---|---|---|---|---|
| Surname | | | | | | Copy from ID/document |
| First names (in full) | | | | | | |
| Surname prefix | | | | | | |
| Date of birth (dd-mm-yyyy) | | | | | | |
| Street address | | | | | | To be specified by employee |
| Place, postcode | | | | | | |
| Occupation and job title | | | | | | |
| **Employee declaration** | | | | | | Explanatory note |
| Have you ever suffered or are you currently suffering from: | Typhoid fever? | **O** | **yes** | **O** | **no** | To be specified by employee |
| | Paratyphoid fever? | **O** | **yes** | **O** | **no** | |
| | Tuberculosis? | **O** | **yes** | **O** | **no** | |
| | Infectious skin disease? | **O** | **yes** | **O** | **no** | |
| If so, which? | | | | | | |
| | Any other infectious disease? | **O** | **yes** | **O** | **no** | |
| If so, which? | | | | | | |
| Employee declaration | I, the undersigned employee, declare that the above information is true and correct to the best of my knowledge and belief. I also declare that if I am suffering, or believe that I am suffering, from an infectious disease while working for the company, I will report this immediately to the company management and to the company's health and safety service. I consent to this declaration being passed on to my employer. | | | | | |
| Place | | | | | | |
| Date (dd-mm-yyyy) | | | | | | |
| Signature of employee | | | | | | |
| **Details of company doctor and health and safety service** | | | | | | Explanatory note |
| Name of company doctor | | | | | | To be completed by the company doctor |
| Name of health and safety service | VisieCare Arbo en HR B.V. | | | | | |
| Street address | Havenkade 100 | | | | | |
| Place, postcode | 1973 AM IJMUIDEN | | | | | |
| **Declaration by company doctor** | | | | | | Explanatory note |
| Declaration by company doctor | I, the undersigned company doctor, declare that I have today examined the above employee and am of the opinion that on the basis of the above information and the results of the examination deemed by me to be necessary, there are currently no objections to the employee working in the above role in his/her employer's fishing business or fish storage company. | | | | | To be completed, signed and stamped by the company doctor |
| Place | | | | | | |
| Date of issue (dd-mm-yyyy) | | | | | | |
| Signature of company doctor and stamp of health and safety service | | | | | | |

**Copy of employer**

## Health declaration

## Valid up to two years after date of issue

| Employee's details | | Explanatory note |
|---|---|---|
| Surname | | Copy from ID/document |
| First names (in full) | | |
| Surname prefix | | |
| Date of birth (dd-mm-yyyy) | | |
| Street address | | To be specified by employee |
| Place, postcode | | |
| Occupation and job title | | |

| Details of company doctor and health and safety service | | Explanatory note |
|---|---|---|
| Name of company doctor | | To be completed by the company doctor |
| Name of health and safety service | VisieCare Arbo en HR B.V>. | |
| Street address | Havenkade 100 | |
| Place, postcode | 1973 AM IJMUIDEN | |

| Declaration by company doctor | | Explanatory note |
|---|---|---|
| Declaration by company doctor | I, the undersigned company doctor, declare that I have today examined the above employee and am of the opinion that on the basis of the above information and the results of the examination deemed by me to be necessary, there are currently no objections to the employee working in the above role in his/her employer's fishing business or fish storage company. | To be completed, signed and stamped by the company doctor |
| Place | | |
| Date of issue (dd-mm-yyyy) | | |
| Signature of company doctor and stamp of health and safety service | | |