



**MINISTRY OF TRANSPORT AND CIVIL AVIATION**  
Male' Republic of Maldives

**MEDICAL FITNESS STANDARDS CERTIFICATE  
FOR SEAFARERS**

*This certificate is issued in accordance with the provision of the regulation 1/9 of the 1978 STCW Convention, as amended and the standard A-1/2 of the MLC, 2006, as amended, and certifies that seafarers are fit for sea service.*

<b>Name :</b>	<b>Address:</b>	<b>Passport No:</b> <input type="text"/>
		<b>ID Number:</b> <input type="text"/>
<b>Date of Birth</b> Day    Month    Year ____ / ____ / _____	<b>Nationality</b>	<b>Gender</b> <b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/>

	Yes	No
<i>Confirm that identification document were checked at the point of examination</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hearing meets the standards?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Unaided Hearing Satisfactory?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Visual acuity meets standards</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Colour vision meets standards</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Date of last colour vision test (Day/Month/year) ____/____/____/____</i>		
<i>Fit for look out duties?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Limitation or restriction on fitness? If "yes" specify limitation or restrictions?</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
<i>Is the seafarers free from any medical condition likely to be aggravated by service at sea or to render the seafarers unfit for such service or to endanger the health of another person on board?</i>	<input type="checkbox"/>	<input type="checkbox"/>

<i>I hereby, confirm that I have been informed about the content of this certificate and of the right to a review in accordance with the paragraph 6 of Section A-1/9.</i>	<i>Seafarers Signature</i>
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<i>Date of Issue</i>	<input type="text"/>
<i>Date of Expiry</i>	<input type="text"/>
<i>Name of the recognized medical practitioner</i>	<input type="text"/>

<i>Signature and Stamp of the recognized medical practitioner</i>
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- The original certificate must kept available while serving on board ship*
- In case of loss of this certificate the holder should notify port and the Ministry*
- The authenticity of this certificate can be verified contacting the Ministry*



MINISTRY OF TRANSPORT AND CIVIL AVIATION  
Male' Republic of Maldives

**MEDICAL TEST (VALID 2 YRS) \* DECK/ENGINE SEAFARERS  
MEDICAL FITNESS CERTIFICATE**

(Issued in compliance with the requirements of Maritime Labour Convention 2006  
and STCW 78 as amended)

Name : \_\_\_\_\_ (In block letters as in Passport)

First : \_\_\_\_\_ Middle : \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth : ( DD/MM/YYYY ) \_\_\_\_\_

Sex : Male :  Female :

Home Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Passport Number : \_\_\_\_\_

Department : (Deck/Engine/Other) \_\_\_\_\_

Type of Ship/Trading area : \_\_\_\_\_

Purpose of sight test : \_\_\_\_\_

Date : \_\_\_\_\_

Signature of Applicant : \_\_\_\_\_

### SIGHT TEST CERTIFICATE

To Be Filled By Approved Medical Practitioner / Examiner

I certify that the above - named sea farer was examined by me with the following results.

#### APPLICANT'S DECLARATION:

Have you ever had any of the following conditions?

- 1. Eye/Vision problem
- 2. High Blood pressure
- 3. Heart/Vascular disease
- 4. Heart Surgery
- 5. Varicose veins/piles 3 of 7
- 6. Asthma/Bronchitis
- 7. Blood disorder
- 8. Diabetes
- 9. Thyroid problem
- 10. Digestive disorder
- 11. Kidney problem
- 12. Skin Problem
- 13. Allergies
- 14. Infectious/contagious diseases
- 15. Hernia
- 16. Genital disorders
- 17. Pregnancy
- 18. Sleep problem
- 19. Do you smoke, use alcohol or drugs ?
- 20. Operation/Surgery
- 21. Epilepsy/Seizers
- 22. Dizziness/Fainting
- 23. Loss of consciousness
- 24. Psychiatric problems
- 25. Depression
- 26. Attempted suicide
- 27. Loss of memory
- 28. Balance problem
- 29. Severe headache
- 30. Ear (Hearing, tinnitus)/Nose/Throat/problem
- 31. Restricted mobility
- 32. Back or joint problem
- 33. Amputation
- 34. Fractures/Dislocations

YES	NO

If you answered "YES" to any of the above questions, please give details

Additional

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

YES	NO

Comments:

Additional questions Yes No

- 42. Are you taking any non-prescription or prescription medication ?

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

I here by 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): \_\_\_\_\_

I here by authorize the release of all my previous medical records from any health professionals ,

health institutions and public authorities to Dr. \_\_\_\_\_

( the approved medical practitioner ) Signature of examinee: \_\_\_\_\_ Date (day /month/year): ...../...../.....

Witnessed by (signature): \_\_\_\_\_ Name (typed or printed ):

Date and contract details for previous medical examination (if known ): \_\_\_\_\_

**MEDICAL EXAMINATION**

Sight

Use of glasses or contract 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

Hearing

	Pure tone and audiometry (threshold values in dB)			
	500HZ	1000HZ	2000HZ	3000HZ
Right ear				
Left ear				

Spech and whisper test (metres)

	Normal	Whisper
Right ear		
Left ear		

**Clinical findings**

Height \_\_\_\_\_ (cm)      Weight \_\_\_\_\_ (kg)  
 Pulse rate \_\_\_\_\_/(minite)      Rhythm \_\_\_\_\_  
 Blood pressure : Systolic \_\_\_\_\_ (mm Hg)      Diastolic \_\_\_\_\_ (mm Hg)  
 Urinalysis : Glucose \_\_\_\_\_ Protein: \_\_\_\_\_ Blood : \_\_\_\_\_

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



**Chest X-ray**

Not performed

Performed on  
(Day/Month/Year) :...../...../.....

Results:  
Other diagnostic test(s) and result(s):

Test

Result:

Medical practitioner's comments and assessment of fitness ,with reasons for any limitations:

**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 look- out duty

Not fit for look-out duty

	<b>Deck service</b>	<b>Engine service</b>	<b>Catering service</b>	<b>Other services</b>
Fit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unfit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without restrictions	<input type="checkbox"/> With restrictions	<input type="checkbox"/> Visual aid required	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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

Date medical certificate issued (day/month/year) ...../...../.....

Number of medical certificate: \_\_\_\_\_

Signature of medical practitioner : \_\_\_\_\_

Medical practitioner information (name,license number ,address):

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Maximum validity of this certificate should not be more than 02 yrs

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