SEAFARERS MEDICAL EXAMINATION REPORT
BOAT MASTER LICENCE /CLASS 6 MASTER / ENGINEER (RESTRICTED)

PART A – TO BE COMPLETED BY THE APPLICANT

Surname (Family Name):	First Name:	Middle Name:
Date of Birth:	Country of Birth:	Nationality:
Permanent Address:		Telephone No:
ID No.	☐ Female ☐ Male	Boat Licence applying for : ☐ Boat Master ☐ Class 6 Master / Engineer (Restricted)

Proof of Identity:
☐ Fiji driver's license ☐ Passport ☐ Other (Specify):

APPLICANT'S PERSONAL DECLARATION (assistance should be offered by medical staff)

Have you ever had any of the following conditions: [Tick the box if YES. Do not tick the box if NO]

☐ Eye / Vision Problem	☐ Do you smoke, use alcohol or drugs?
☐ High Blood Pressure	☐ Migraines / Severe Headache
☐ Heart / Vascular disease	☐ Ear/nose/throat problem
☐ Diabetes	☐ Back or Joint Problem
☐ Kidney problem	☐ Fractures

If you answered Yes to the above questions, please write details below:

ADDITIONAL INFORMATION:

	YES	NO
1. Are you allergic to any medication	☐	☐
2. Are you taking any non-prescription or prescription medications	☐	☐
3. Do you have any pre-existing medical conditions?	☐	☐
If yes, please list the medication taken and the purpose or dosage:		

APPLICANT'S DECLARATION

The following should be signed in the presence of the examining medical officer.

WARNING: Giving false of misleading information is a serious criminal offence and may lead to prosecution.

Are you aware of ANY circumstances regarding your health which may interfere with the satisfactory discharge of the duties of your designated position / occupation?

If Yes, give details:

I hereby declare that, to best of my knowledge my personal statements are true and correct.

Applicant's signature …… Date……/……../……

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AUTHORITY TO DIVULGE MEDICAL INFORMATION

If, as a result of this or subsequent examinations for the purposes of assessing my medical fitness for duty at sea, the examining medical officer requires relevant medical details from my treating medical advisor(s), permission is hereby granted to obtain information from:

Dr…… Address & phone……..

Dr…… Address & phone……..

Applicant's Signature…….. Date……../……/……

PART B TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER

VISION

Is there any visual effect of the eyes? ☐ YES ☐ NO

Color Vision:

☐ Normal ☐ Doubtful ☐ Defective

For further referral: ☐

SPEECH / HEARING /PHSYICAL

	YES	NO	Comment if YES:
Is there any defect in speech?	☐	☐	
Is there any defect in hearing?	☐	☐	
Is there normal use of limbs?	☐	☐	
Are there any mobility restrictions?	☐	☐	

DECLARATION OF MEDICAL PRACTITIONER:

	YES	NO
Applicant's identification documents were checked	☐	☐
Hearing meets the standards	☐	☐
Color Vision meets the standards	☐	☐
Fit for lookout duties	☐	☐

THIS IS TO CERTIFY THAT I HAVE EXAMINED THE APPLICANT AND THAT MY FINDINGS ARE RECORDED IN THIS MEDICAL REPORT

RESULT:

☐ **FIT FOR SEA DUTY** ☐ **UNFIT FOR SEA DUTY** ☐ **FIT WITH LIMITATIONS**

Signature of qualified medical practitioner	Applicant's signature (In presence of medical practitioner)
Medical practitioner's stamp	Date of Examination