



DR. MD. AYUBUR RAHMAN M.B.B.S (Reg. No: A-11820)
Authorized Medical Practitioner for seafarer by Department of Shipping, Govt. of Bangladesh

Saba Diagnostic Centre

Taher Chamber (Ground Floor), 10 Agrabad Commercial Area, Chittagong, Bangladesh.
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Certificate No.:

REPORT OF MEDICAL FITNESS EXAMINATION

MEDICAL EXAMINATION UNDER MERCHANT SHIPPING RULES-2000, ISM CODE G.2 / STCW CODE 1/9 AND ILO CONVENTION NO 73.

Name in full:	DIBRAJ DAS		
Rank:	3 RD OFFICER	Sex:	MALE
Date of birth:	17-04-1995	Nationality:	BANGLADESHI
Passport No:	A00117296	CDC No.:	C/018896

APPLICANT'S DECLARATION

Have you ever had any of the following conditions? (Please tick yes or no, if needed give details)

	Yes	No	
01. Hospitalize for whatever reason at all in the past?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
02. An operation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
03. Tuberculosis or abnormal chest X-Ray?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
04. Sexually transmitted diseases?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
05. Mental illness?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
06. Convulsions, Fits, or Epilepsy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
07. Ear or hearing problem?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
08. High blood pressure?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
09. Chest pain or heart trouble?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
10. Asthma or chronic bronchitis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
11. Peptic ulcer or blood in the vomit or stool?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
12. Urinary problems?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
13. Pain in the joints or back?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
14. Diabetes?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
15. Allergic to any drugs or foods or any others?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
16. Problem in vision?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
17. Do you take alcohol, drugs or smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
18. Have you any medical consultation for any things At all during the last six months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
19. Do you have a medical or others condition Not already mentioned above?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____

I declare that the information given above is correct to the best of my knowledge. I consent to the examining doctor to endorse any medical information on the medical fitness certificate.

Signature of the applicant	
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07-2024-0467-