

## Medical Declaration

As per medical standards of ILO- MLC 2006, as amended STCW 2010

### Medical Examination of Seafarers Examinee's Declaration

Name (last, first, middle):	YOUSUF MOHAMMED
Date of birth (day/month/year):	01-02-1973
Sex: <input checked="" type="checkbox"/> Male / <input type="checkbox"/> Female	MALE
Home address:	SOUTH HALISHAHR, BANDARTILA
	CEPZ, CHITTAGONG
Passport No./Discharge book No.:	BX 0197245      BDS 0018 RB
Department <input checked="" type="checkbox"/> Deck/Engine/Radio/Food handling/other):	BOSUN / DECK
Rank:	BOSUN
Routine and emergency duties (if known):	BOTH
Type of ship <input checked="" type="checkbox"/> (Cargo, Tanker, Passenger):	TANKER
Trade area <input checked="" type="checkbox"/> (coastal, tropical, worldwide):	WORLDWIDE

### Seafarer's Personal Declaration

(Assistance should be offered by medical staff)

Have you ever had any of the following conditions?

	Condition	Yes	No		Condition	Yes	No
1	Eye/vision problem		<input checked="" type="checkbox"/>	18	Sleep problem		<input checked="" type="checkbox"/>
2	High blood pressure		<input checked="" type="checkbox"/>	19	Do you smoke, use alcohol or drugs?		<input checked="" type="checkbox"/>
3	Heart/vascular disease		<input checked="" type="checkbox"/>	20	Operation/surgery		<input checked="" type="checkbox"/>
4	Heart surgery		<input checked="" type="checkbox"/>	21	Epilepsy/seizures		<input checked="" type="checkbox"/>
5	Varicose veins/piles		<input checked="" type="checkbox"/>	22	Dizziness/fainting		<input checked="" type="checkbox"/>
6	Asthma/bronchitis		<input checked="" type="checkbox"/>	23	Loss of consciousness		<input checked="" type="checkbox"/>
7	Blood disorder		<input checked="" type="checkbox"/>	24	Psychiatric problems		<input checked="" type="checkbox"/>
8	Diabetes		<input checked="" type="checkbox"/>	25	Depression/Hepatitis		<input checked="" type="checkbox"/>
9	Thyroid problem		<input checked="" type="checkbox"/>	26	Attempted suicide		<input checked="" type="checkbox"/>
10	Digestive disorder		<input checked="" type="checkbox"/>	27	Loss of memory		<input checked="" type="checkbox"/>
11	Kidney problem		<input checked="" type="checkbox"/>	28	Balance problem		<input checked="" type="checkbox"/>
12	Skin problem		<input checked="" type="checkbox"/>	29	Severe headaches		<input checked="" type="checkbox"/>
13	Allergies		<input checked="" type="checkbox"/>	30	Ear (hearing, tinnitus)/nose/throat problem		<input checked="" type="checkbox"/>
14	Infectious/contagious diseases		<input checked="" type="checkbox"/>	31	Restricted mobility		<input checked="" type="checkbox"/>
15	Hernia		<input checked="" type="checkbox"/>	32	Back or joint problem		<input checked="" type="checkbox"/>
16	Genital disorder		<input checked="" type="checkbox"/>	33	Amputation		<input checked="" type="checkbox"/>
17	Pregnancy <i>N/A</i>			34	Fractures/dislocations		<input checked="" type="checkbox"/>