



**DR. M. 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**

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: <b>MAINUL HASAN SIMUL</b>	
Rank: <b>JR. FOURTH ENGINEER</b>	Sex: <b>MALE</b>
Date of birth: <b>02-01-1995</b>	Nationality: <b>BANGLADESHI</b>
Passport No: <b>A02293757</b>	CDC No.: <b>C/O/9630</b>

**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.

<b>Signature of the applicant</b>	✓
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