



**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: <b>MOHAMMAD SHARIFUL ISLAM</b>	
Rank: <b>Third Officer</b>	
Date of birth: <b>06/12/1992</b>	Sex: <b>MALE</b>
Passport No: <b>EF0212044</b>	Nationality: <b>BANGLADESHI</b>
CDC No.: <b>C/O/8869</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<br>At all during the last six months? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| 19. Do you have a medical or others condition<br>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>	<i>✓ SHARIF</i>
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