



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

Saba Diagnostic Centre

Taher Chamber (Ground Floor), 10 Agrabad Commercial Area, Chittagong, Bangladesh.
 Tel: 0088-031-715678, E-mail: sdc-ctg@yahoo.com, www.drayubur.com

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: SHAI F UDDIN	
Rank: 3/0	Sex: MALE
Date of birth: 31-12-1988	Nationality: BANGLADESHI
Passport No: A 017 87 174	CDC No.: C1010172

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 type="checkbox"/>	_____
02. An operation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
03. Tuberculosis or abnormal chest X-Ray?	<input type="checkbox"/>	<input type="checkbox"/>	_____
04. Sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>	_____
05. Mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
06. Convulsions, Fits, or Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
07. Ear or hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>	_____
08. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
09. Chest pain or heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Asthma or chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Peptic ulcer or blood in the vomit or stool?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Urinary problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Pain in the joints or back?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Allergic to any drugs or foods or any others?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Problem in vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Do you take alcohol, drugs or smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Have you any medical consultation for any things At all during the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Do you have a medical or others condition Not already mentioned above?	<input type="checkbox"/>	<input 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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