



TITLE:- PRE-JOINING MEDICAL EXAMINATION  
REPORT/CERTIFICATE

Issue No 00  
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Appendix I  
Medical Exam Form  
CONFIDENTIAL FORM

Additional questions

- |                                                                                               | Yes                                 | No                                  |
|-----------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| 35. Have you ever been signed off as sick or repatriated from a ship?                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 36. Have you ever been hospitalized?                                                          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 37. Have you ever been declared unfit for sea duty?                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 38. Has your medical certificate ever been restricted or revoked?                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 39. Are you aware that you have any medical problems, diseases or illnesses?                  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 40. Do you feel healthy and fit to perform the duties of your designated position/occupation? | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 41. Are you allergic to any medications?                                                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

Comments.

Fit For Duty on Board Ship

42. Are you taking any non-prescription or prescription medications?

If yes, please list the medications taken and the purpose(s) and dosage(s).

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

Signature of examinee: [Signature]

Date (day/month/year): 11 NOV / 2021

Witnessed by: (Signature) [Signature]

Name: (Typed or printed) DR. MD. AYUBUR RAHMAN

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to DR. MD. AYUBUR RAHMAN (The approved medical examiner).

Signature of examinee: [Signature]

Date (day/month/year): 11 NOV / 2021

Witnessed by: (Signature) [Signature]

Name: (Typed or printed) DR. MD. AYUBUR RAHMAN

Date and contact details for previous medical examination (if know):

10, Agrabad C/A, Chittagong.  
Regn. No. A-11820

(CONTROLLED DOCUMENT)

Quality Manual: Naaf Marine Services, Chittagong, Bangladesh: July 2012