



HAQUE & SONS LTD.

Summana Haque Tower, 1267/A, Goshaldanga, Agrabad C/A, Chattogram, Bangladesh.
Tel : +880 31 716214-6, Fax : +880 31 710530



Accredited By : BMDC
Accreditation No. A 11820

PATIENT CONTROL NUMBER:
H030895

MEDICAL EXAMINATION CERTIFICATE

SURNAME		FIRST NAME AKHTARUZZAMAN		MIDDLE NAME	
PLACE AND DATE OF BIRTH CUMILLA 11-Jan-1999		PASSPORT NUMBER EF0144626		SEAMAN'S BOOK NUMBER T33482	
NATIONALITY : BANGLADESHI		SEX : <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		VESSEL TYPE : CHEM. TANKER TRADING AREA : WORLD WIDE	
PERMANENT HOME ADDRESS : BAKIHATI, AZIARA BAZAR NANGALKOT CUMILLA				CONTACT NUMBER : 1777448491	
				RANK : WIPER	

Have you ever had any of the following conditions?

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

If any of the above questions were answered "yes", please give details.

Additional questions

Question	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 hospitalised?	<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? YES NO

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

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 (approved medical practioner) I also certify that my history contained above is true and any false statement will disqualify me from my employment, benefits and claims.

[Signature]

Signature of Seafarer

MEDICAL EXAMINATION

Weight **62kg** Height (cm) **165** BM **22.7** Blood Pressure: Systolic-**110** Diastolic **65** PULSE: **94** MEN

Hearing by Audiometry		
Right	<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
Left	<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate

Audiometry			
500	1000	2000	3000

Hearing by Whisper Test	
<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate

Hearing meets the standards as laid down in STCW Code Section A-1/9 ? YES NO