



Form no. USSL006

RECORD OF SEAFARERS FOR MEDICAL EXAMINATION

Name (last/first&middle): NASER, MOHAMMAD ABU  
 Date of Birth (day/month/year): 03-01-1992 Sex:  Male  Female  
 Home address: ARAFORA, DURGAPOR, AGARSHA SADAR, CUMILLA, BD.  
 Passport/Discharge Book No: CLOT 7473 Department: (deck/engine/radio/food handling/other): ZALENGER  
 Routine and emergency duties: BOTH  
 Type of ship (container, tanker, passenger, fishing): TANKER Trade area (e.g., coastal, tropical, worldwide): W. WIDE

DR. MD. AYUBUR RAHMAN  
 M.B.B.S. P.G.T. (Medicine)  
 19, Agrabad C/A, Chittagong  
 Reg. No. A-11820

EXAMINEE'S PERSONAL DECLARATION (ASSISTANCE SHOULD BE OFFERED BY MEDICAL STAFF)

Have you ever had any of the following conditions?

SL	Condition	Yes	No.	SL	Condition	Yes	No.
1	Eye / vision problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18	Sleep problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2	High blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19	Do you smoke , use alcohol or drugs?	<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/piles	<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	Loss of consciousness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9	Thyroid problems	<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 problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28	Balance problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12	Skin problems	<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 (hearing/tinnitus) 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 or joint 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 <u>NCA</u>	<input type="checkbox"/>	<input type="checkbox"/>	34	Fractures/dislocation	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If any of the above questions were answered "yes", please give details (separate sheet can be used)

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"/>	39	Are you aware that you have any medical problems, diseases or illness?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
36	Have you ever been hospitalized?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	40	Do you feel healthy and fit to perform the duties of your designed position/occupation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
37	Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	41	Are you allergic to any medications?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
38	Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				

Comments (separate sheet can be used):

**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). (separate sheet can be used)

The Seafarer concerned is not suffering from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board

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

Signature of examinee: NASER Date (day/month/year): 08 FEB 2023

Witnessed by: (Name: DR. MD. AYUBUR RAHMAN) Signature: [Signature]  
M.B.B.S. P.G.T. (Medicine)

Date and contact details for previous medical examination (if known): \_\_\_\_\_  
19, Agrabad C/A, Chittagong