



# NYK SHIPMANAGEMENT PTE LTD

1 HarbourFront Place #15-01 HarbourFront Tower One Singapore 098633  
Tel: 65-6416 7500 Fax: 65-6416 9922

## REPORT OF MEDICAL EXAMINATION OF SEAFARER BY AN APPROVED MEDICAL EXAMINER

As per ISM / STCW code 1/9, ILO convention 147 and MLC 2006

**Part A** – to be completed by the Seafarer who is responsible for answering each question accurately.

Seafarer's Name in Full (BLOCK CAPITALS) <b>A.R.M. SAIFUL ISLAM</b>		Sex: <b>MALE</b> FEMALE
Date of Birth: <b>30-12-1970</b> day / month / year	Place of Birth: <b>LAKSHMIPUR</b>	Nationality: <b>BANGLADESHI</b>
Type of ID documents: <b>CD/1906</b> SB No. / Passport No: <b>EE0503539</b>	Dept: <b>Deck</b> Engine / Catering / Others Rank: <b>MASTER</b>	Type of Ship: <b>1</b>
Home Address: <b>13A, ALIA TOWER 10, MEMEDIBAG, CTG</b>	Routine and emergency duties: <b>BOTH</b>	Trading area: e.g. coastal / <b>worldwide</b>

Seafarer's Declarations (please tick) – Have you ever had any of the following conditions?

	Yes	No		Yes	No		Yes	No
1. Eye Vision Problem		<input checked="" type="checkbox"/>	13. Allergies		<input checked="" type="checkbox"/>	25. Depression		<input checked="" type="checkbox"/>
2. High Blood Pressure		<input checked="" type="checkbox"/>	14. Severe Headaches		<input checked="" type="checkbox"/>	26. Attempted Suicide		<input checked="" type="checkbox"/>
3. Heart Vascular Disease		<input checked="" type="checkbox"/>	15. Hernia		<input checked="" type="checkbox"/>	27. Loss of Memory		<input checked="" type="checkbox"/>
4. Hear Surgery		<input checked="" type="checkbox"/>	16. Genital Disorder		<input checked="" type="checkbox"/>	28. Balance Problem		<input checked="" type="checkbox"/>
5. Varicose Veins / Piles*		<input checked="" type="checkbox"/>	17. pregnancy <b>N/A</b>			29. Infectious / Contagious Diseases*		<input checked="" type="checkbox"/>
6. Asthma / Bronchitis		<input checked="" type="checkbox"/>	18. Sleep Problem		<input checked="" type="checkbox"/>	30. Ear (Hearing, Tinnitus / Nose / Throat Problem)		<input checked="" type="checkbox"/>
7. Blood Disorder		<input checked="" type="checkbox"/>	19. Restricted Mobility		<input checked="" type="checkbox"/>	31. Do you smoke, use alcohol or drugs?		<input checked="" type="checkbox"/>
8. Diabetes		<input checked="" type="checkbox"/>	20. Operation / Surgery*		<input checked="" type="checkbox"/>	32. Back or Joint Problem		<input checked="" type="checkbox"/>
9. Thyroid Problem		<input checked="" type="checkbox"/>	21. Epilepsy / Seizures*		<input checked="" type="checkbox"/>	33. Amputation		<input checked="" type="checkbox"/>
10. Digestive Disorder		<input checked="" type="checkbox"/>	22. Dizziness / Fainting*		<input checked="" type="checkbox"/>	34. Fracture / Dislocations*		<input checked="" type="checkbox"/>
11. Kidney Problem		<input checked="" type="checkbox"/>	23. Loss of Consciousness		<input checked="" type="checkbox"/>	35. Chicken Pox / Chicken Pox Vaccine		<input checked="" type="checkbox"/>
12. Skin Problem		<input checked="" type="checkbox"/>	24. Psychiatric Problems		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>

If you answer "yes" to any of the above questions, please provide details:

36. Have you ever been signed off as sick or repatriated from a ship?		<input checked="" type="checkbox"/>
37. Have you ever been hospitalized?		<input checked="" type="checkbox"/>
38. Have you ever declared unfit for sea duty?		<input checked="" type="checkbox"/>
39. Has your medical certificate ever been restricted or revoked?		<input checked="" type="checkbox"/>
40. Are you aware that you have any medical problems, diseases or illnesses?		<input checked="" type="checkbox"/>
41. Do you feel healthy and fit to perform the duties of your designated position / occupation?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
42. Are you allergic to any medication?		<input checked="" type="checkbox"/>
43. Are you using any non-prescription or prescription medication?		<input checked="" type="checkbox"/>

If you answer "yes", please list the medications taken, the purpose(s) and the dosage:

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

Also, I hereby authorize the release of all my medical records (including my last Seafarer Medical Certificate) from any health professional, health institutions and public authorities to relevant maritime agencies, examining/authorized physician, employer, manning agent.

**VALID FOR TWO YEARS**

**03 NOV 2022**

Date

*Signature of Seafarer*  
Signature of Seafarer

*Signature of Medical Examiner*  
DR. MD. AYUBUR RAHMAN  
Name of Signatory (Medicine)  
Taher Chamber  
10, Agrabad C/A, Chittagong.  
Regn. No. A-11820

\* - Please Strike out which is NOT APPLICABLE

07-2022-1352