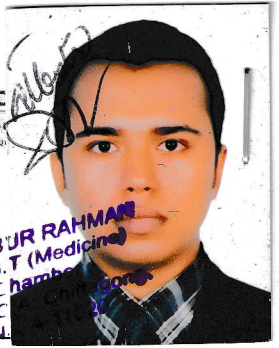


Form no. USSL006

RECORD OF SEAFARERS FOR MEDICAL EXAMINATION



Name (last/first&middle): FATTAH HANIDUL

Date of Birth (day/month/year): 03-02-1991 Sex: Male Female

Home address: 93, EAST NASIRABAD, CHATTAGONG

DR. MD. AYUBUR RAHMAN
M.B.B.S. P.G.T (Medicine)
Taher Chamber
10, Agrabad C/A
Regn. No. A-11820

Passport/Discharge Book No: B00027621 Department: (deck/engine/radio/food handling/other): 2ND OFFICER

Routine and emergency duties: BOTH

Type of ship (container, tanker, passenger, fishing): TANKER Trade area (e.g., coastal, tropical, worldwide): WORLDWIDE

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>N/A</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	<input type="checkbox"/>	<input checked="" type="checkbox"/>
36	<input type="checkbox"/>	<input checked="" type="checkbox"/>
37	<input type="checkbox"/>	<input checked="" type="checkbox"/>
38	<input type="checkbox"/>	<input checked="" type="checkbox"/>
39	<input type="checkbox"/>	<input checked="" type="checkbox"/>
40	<input checked="" type="checkbox"/>	<input type="checkbox"/>
41	<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: [Signature]

Date (day/month/year): 12 MAY 2022

Witnessed by: (Name: DR. MD. Ayubur Rahman)

Signature: [Signature]

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

DR. MD. AYUBUR RAHMAN
M.B.B.S. P.G.T (Medicine)