

# AMERICAN CLUB PRE-EMPLOYMENT MEDICAL EXAMINATION FORM-

**IMPORTANT:** The original of this form is to be kept by the seafarer. A copy must be kept by the clinic.

Date of Examination: 12 JUL 2025 (dd/mm/yyyy)



Name:	<u>BIPUL</u>	<u>MD MARUF</u>	<u>AZAD</u>
	Last Name	First Name	Middle Name
Mailing Address:	<u>marufazad1218@gmail.com</u> <u>COLLEGE PARA, WARD-04, GAJBANDHA SADAR-5700, GAJBANDHA.</u>		
Date of Birth (dd/mm/yyyy)	Blood Type/Group	Place of Birth (City/Country)	Name of Ship/Vessel
<u>07-10-1994</u>	<u>B+</u>	<u>GAJBANDHA</u>	<u>MV BRAVE ROYAL</u>
Medical Certificate No.:		Seafarer's Certificate No.:	<u>1013589</u>

✓  
Azad

Seafarer's Signature

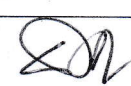
**NOTE:** The passing or failure of the medical examinations for the following is based upon the 2019 American Club Pre-Employment Medical Examination Guidelines. All relevant examinations must be completed and recorded below.

Examination	Results of Examination		Examination	Results of Examination	
	Pass	Fail		Pass	Fail
1. Medical History Questionnaire (attached)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Ultrasound examination (presence of gall and/or kidney stones)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Physical Examination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Hep B Antigen	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Dental Examination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. Hep C Antibodies	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Psychological Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. VDRL	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Visual Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. HIV Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Color Vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. Stress Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Audiometry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	19. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Chest X-ray	<input checked="" type="checkbox"/>	<input type="checkbox"/>	20. Fasting Blood Sugar	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Electro Cardiogram (ECG or EKG)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Glycosylated Haemoglobin (HbA1c)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Urinalysis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Liver Function Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. Fecalysis (food service/handlers only)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Alcohol/Drug Test	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. Complete Blood Count	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Spirometry	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If failed in any of the abovementioned examinations, please provide an explanation for the failure with the associated examination number:

Exam # _____
Exam # _____
Exam # _____

Has medication been prescribed because of this PEME? YES  NO  If "YES", the American Club PEME Declaration Form MUST BE completed (third page).

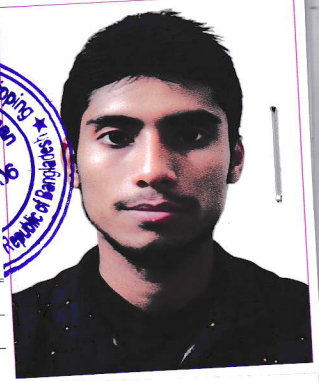
Name of Medical Clinic:	<b>SABA DIAGNOSTIC CENTER</b>	Signature of Physician
Address of Medical Clinic:	Taher Chamber, 10, Agrabad C/A, Chattogram	
Contact Phone No.:	<b>02-333313678</b>	
Contact Fax No.:		
Name and Degree of Physician:	<b>DR. MD. Ayubur Rahman</b> M.B.B.S., F.G.T. (Medicine) Taher Chamber,	
Name of Physician's Licensing Body:	<b>10, Agrabad C/A, Chittagong</b> BMDC Reg. No. A-11820 AND APPROVED BY DG Shipping Govt. of Bangladesh.	
Date of Issue of Physician's License:	<b>23-02-1984</b>	 <b>DR. MD. Ayubur Rahman</b> M.B.B.S., F.G.T. (Medicine) Taher Chamber, 10, Agrabad C/A, Chittagong BMDC Reg. No. A-11820 AND APPROVED BY DG Shipping Govt. of Bangladesh. Hologram to be placed here
Date of Completed PEME Examination:	<b>12 JUL 2025</b>	
Expiry Date for PEME: (cannot be less than one calendar year)	<b>11 JUL 2027</b>	





# AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

**IMPORTANT:** This medical history form must be completed in the presence of the clinic physician.



American Club Hologram Sticker No. (from previous page): \_\_\_\_\_  
Doctor's Initials: \_\_\_\_\_

Name: **BIPUL** Last Name      **MD MARUF** First Name      **AZAD** Middle Name

Home Address: **COLLEGE PARA, WABD-04, GAIBANDHA SADAR-5700, GAIBANDHA**

Date of Birth (dd/mm/yyyy): **07-10-1994**      Phone No.: **01777-311796**      Seaman's Certificate No.: **CP0/13589**      Employer: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_      Relationship: **UNCLE**      Phone No.: **01716918173**

Address: **COLLEGE PARA, WARD-04, GAIBANDHA**      Physician's Phone No.: **02-333313678**

Personal Physician or Clinic: \_\_\_\_\_      Address: \_\_\_\_\_

Seafarer's Signature:

Family History					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy/Seizure	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If "YES" to any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_  
Any other major medical or physical conditions? \_\_\_\_\_

MALE ONLY			FEMALE ONLY		
	YES	NO		YES	NO
Prostate Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Testicular Lumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Penile Discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" to any of the above, please explain: \_\_\_\_\_

Are you currently under a doctor's care?  YES  NO  
If "YES", for what problem(s) \_\_\_\_\_  
Physician's name and address (if different from the one noted above) \_\_\_\_\_

Have you had surgeries or have been hospitalized?  YES  NO  
If "YES", provide the date(s) and give details below: \_\_\_\_\_

Date of last Tetanus vaccination: \_\_\_\_\_ (dd/mm/yyyy)  
List other vaccinations/dates: \_\_\_\_\_ (dd/mm/yyyy)  
Date of last dental cleaning: \_\_\_\_\_ (dd/mm/yyyy)  
Date of any recent dental work: \_\_\_\_\_ (dd/mm/yyyy)

Overall, would you say that your health is (please check only one):  
 Excellent       Good       Fair

Have you received treatment for the following?					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Jaundice or Hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Slipped Disk	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wrist Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fractured Vertebrae	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rash or Skin Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hernia/Hydrocele	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20/20 Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Epilepsy/Seizure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Drug Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Breakdown	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Psychological Impairment, Depression or Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Sexually Transmitted Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>			

Allergies: \_\_\_\_\_ YES  NO   
Do you have any allergies?  YES  NO  
If you have allergies, please describe: \_\_\_\_\_

	YES	NO	
Do you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how long? _____
			If "YES", how many packs per day? _____
Do you drink alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how much and how often? _____
Do you use or take any drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", name the drugs and how often used: _____

Are you presently on any medication(s)? YES  NO   
If "YES", please list prescription and over the counter medications you take regularly: \_\_\_\_\_

**DECLARATION**  
I, **MD MARUF AZAD BIPUL**, Seaman's Number **CP0/13589**, Hereby Declare that I have made full disclosure of all of my medical history to the Doctors and staff of this Clinic. I am aware that the information supplied by forms the basis upon which I will be offered employment as a Seafarer. I understand that in the event of any misrepresentation either by statement or omission I will lose the right to benefit from sick pay and / or compensation which would otherwise be due under the Contract of Employment or under any Collective Bargaining Agreement. I Also Hereby consent to my medical records being made available upon demand to my employers and/or the Owners and/or Insurance of the Vessel or their authorized representatives.

**Fit For Duty on Board Ship**



**AMERICAN CLUB DECLARATION FORM —2019**

**IMPORTANT:** If medication has been prescribed by the clinic, the seafarers BMI has been found to be between 30 and 32.9, or any other relevant medical condition requiring lifestyle changes has been found, as a condition of issuing this American Club PEME certificate, this form MUST BE completed by the clinic.

American Club Hologram Sticker No. (from first page): \_\_\_\_\_

Doctor's Initials: \_\_\_\_\_

I, MD MARUF AZAD BIPTUL, Seaman's Number C/O/13589, **Hereby Declare** that I understand that I have been issued an American Club pre-employment medical examination form according to the standards of American P&I club so that I may be employed on the understanding that I will be responsible for taking the following prescribed medication(s) (name(s) of prescribed medication(s)):

In addition, the following medical recommendation have been given to me by the doctor for the medical condition of (name(s) of prescribed medication(s))

(name of doctor(s), name of clinic, **this physician is required to sign this form at the bottom**)

has explained to me what my condition is, what medication is required and how this should be administered.

I hereby agree to ensure that I follow taking prescribed medication and following medical recommendation given to me by the doctor and that I will take responsibility for making arrangements to secure the medication during the course of my employment as prescribed. Any additional medical evaluations and testing I may need because of the pre-existing condition are to my responsibility.

My signature below acknowledges my receipt and understanding of this Declaration and I that I had an opportunity to discuss any questions or concerns about this notice with a member of the PEME team and that my noncompliance with this undertaking have been fully explained to me and I confirm that I understand the same.

I have given the original of this Declaration to the medical facility where the American Club pre-employment medical examination form has been issued. I confirm to keep the copy of this Declaration through the term of validity of pre-employment medical examination form.

Seafarer's  Signature:

Date: 07-12-2025 (mm/dd/yyyy)

Witnessed by:   
(Physician's signature):

**DR. MD. Ayubur Rahman**  
M.B.B.S, P.G.T (Medicine)  
Taher Chamber,  
10, Agrabad C/A, Chittagong  
BMDC Reg. No. A-11820  
AND APPROVED BY  
DG Shipping  
Govt. of Bangladesh