



**AMERICAN CLUB PRE-EMPLOYMENT MEDICAL EXAMINATION FORM—2019**

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

Date of Examination: 23 SEP 2025 (dd/mm/yyyy)



Name:	<u>ALAM</u>	<u>MOHAMMED</u>	<u>KHORSHED</u>
	Last Name	First Name	Middle Name
Mailing Address:	<u>VILL-JATRAPUR, P.O: KASHINAGAR, PS: CHOUDDA-GRAM, DIST: CUMILLA</u>		
Date of Birth (dd/mm/yyyy)	Blood Type/Group	Place of Birth (City/Country)	Name of Ship/Vessel
<u>18/12/1980</u>	<u>O+ve</u>	<u>CUMILLA</u>	<u>M.V. BRAVE ROYAL</u>
Medical Certificate No.:		Seafarer's Certificate No.:	<u>CB04517</u>

KORSHED

Seafarer's Signature

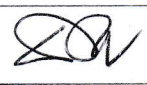
NOTE: The passing or failure of the medical examinations for the following is based upon the 2019 American Club Pre-Employment Medical Examination Guidelines. All relevant examinations must be completed and recorded below.

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:	<u>SABA DIAGNOSTIC CENTER</u>	Signature of Physician
Address of Medical Clinic:	<u>Taher Chamber, 10, Agrabad C/A, Chattogram</u>	
Contact Phone No.:	<u>02-333313678</u>	
Contact Fax No.:		
Name and Degree of Physician:	<u>DR. MD. Ayubur Rahman, M.B.B.S., P.G.T (Medicine)</u>	 DR. MD. Ayubur Rahman, M.B.B.S., P.G.T (Medicine) Taher Chamber, 10, Agrabad C/A, Chattogram BMDC Reg. No. A-11820 AND APPROVED BY DG Shipping, Govt. of Bangladesh
Name of Physician's Licensing Body:	<u>23-02-1984</u>	
Date of Issue of Physician's License:	<u>23 SEP 2025</u>	
Date of Completed PEME Examination:	<u>23 SEP 2025</u>	
Expiry Date for PEME: (cannot be less than one calendar year)	<u>22 SEP 2027</u>	





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Medical Certificate No.:		Seafarer's Certificate No.:	<u>1014517</u>

KNSC

Seafarer's Signature

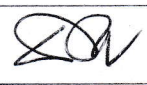
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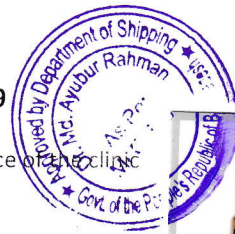
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Address of Medical Clinic:	<u>Taher Chamber, 10, Agrabad C/A, Chattogram</u>	
Contact Phone No.:	<u>02-333313678</u>	
Contact Fax No.:		
Name and Degree of Physician:	<u>DR. MD. Ayubur Rahman</u>	 DR. MD. Ayubur Rahman M.B.B.S., P.G.T (Medicine) M.B.B.S., P.G.T (Medicine) Taher Chamber, Agrabad C/A, Chattogram BMDC Reg. No. A-11820 AND APPROVED BY DG Shipping Govt. of Bangladesh
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# AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019



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

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



✓ KLMC  
 Seafarer's Signature

Name:	ALAM	MOHAMMED	KHORSHED
	Last Name	First Name	Middle Name
Home Address:	VILL-JATRAPUR, P.O: KASHINAGAR, P.S-CHOUDHAGRAM, DIST: CUMILLA		
Date of Birth (dd/mm/yyyy)	Phone No.	Seaman's Certificate No.	Employer
18/12/1980	01712340213	CP014517	VM L
In case of emergency, notify:	Relationship:	Address:	Phone No.:

Personal Physician or Clinic:	Physician's Phone No.:	02-333313678
Address:		

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	YES	NO	FEMALE ONLY	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
	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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
	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If you have allergies, please describe: _____ _____		

Do you smoke?	YES	NO	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how long? If "YES", how many packs per day?
Do you drink alcohol?	YES	NO	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how much and how often?
Do you use or take any drugs?	YES	NO	
	<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
	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If "YES", please list prescription and over the counter medications you take regularly:		

**DECLARATION**  
 I, MOHAMMED KHORSHED ALAM CP014517, Seaman's Number, 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, MAHAMMED KHORSHED ALAM, Seaman's Number 010/4817 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: ✓ KRASHED

Date: 23 SEP 2025 (mm/dd/yyyy)

Witnessed by: [Signature]  
(Physician's signature):

**DR. MD. Ayubur Rahman**  
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