

APPLICATION FORM FOR MEDICAL EXAMINATION FOR SEAFARERS

Surname	First Name	Middle Name(s)	Sex	Age	Weight	Job Title
MEDICAL HISTORY: Do any of the medical conditions listed apply?			Indicate additional comments below (33)			
1 Loss of Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	6 Hypertension	Yes <input type="checkbox"/> No <input type="checkbox"/>	11 Epilepsy of Attacks	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2 Colour Blindness	<input type="checkbox"/> <input type="checkbox"/>	7 Chest Pains	<input type="checkbox"/> <input type="checkbox"/>	12 Kidney Disease	<input type="checkbox"/> <input type="checkbox"/>	
3 Seizures	<input type="checkbox"/> <input type="checkbox"/>	8 Diabetes	<input type="checkbox"/> <input type="checkbox"/>	13 Venereal Disease	<input type="checkbox"/> <input type="checkbox"/>	
4 Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/>	14 Narcotics History	<input type="checkbox"/> <input type="checkbox"/>	
5 Heart Difficulties	<input type="checkbox"/> <input type="checkbox"/>	10 Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	15 Other Illness	<input type="checkbox"/> <input type="checkbox"/>	
CLINICAL EVALUATION - Note: Describe every abnormality and enter pertinent item number before each comment (33)						
16 Head, Face, Neck, Scalp	Normal Yes <input type="checkbox"/> No <input type="checkbox"/>	20 Genito - Urinary (Hematurial, Pyuria)	Normal Yes <input type="checkbox"/> No <input type="checkbox"/>	21 Rectum (Blood, Masses)	<input type="checkbox"/> <input type="checkbox"/>	
17 Chest and Lungs	<input type="checkbox"/> <input type="checkbox"/>	22 Lower Extremities (Varicosities)	<input type="checkbox"/> <input type="checkbox"/>	23 Appearance & Mental State	<input type="checkbox"/> <input type="checkbox"/>	
18 Vascular system	<input type="checkbox"/> <input type="checkbox"/>					
19 Abdomen and Viscera	<input type="checkbox"/> <input type="checkbox"/>					
24 VISION		25 COLOUR PERCEPTION		26 HEARING		
Right Eye	Uncorrected 20/	Corrected 20/	Book <input type="checkbox"/>	Lantern <input type="checkbox"/>	Right Ear _____	
Left Eye	20/	20/	Yellow _____	Red _____	Left Ear _____	
Both Eyes	20/	20/	Green _____	Blue _____		
27 BLOOD PRESSURE		28 RESPIRATION/MIN		29 PULSE		
Systolic _____				Rate _____ Regular <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>		
Diastolic _____						
LABORATORY FINDING:						
30 Chest Radiography X-Ray		Report: _____				
31 URINALISIS: Specify Gravity		Albumin	Sugar	32 VDRL: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		
MEDICAL REQUIREMENTS						
1. Applicants who have a Medical History of past or present epilepsy, acute venereal disease, neurosyphilis, varicose veins or use of narcotics or other diseases according to medical criterion will be disqualified.						
2. CLINICAL EVALUATION						
b.1 Vision Requirements for:						
	DECK OFFICERS	ENGINEER OFFICERS	SEISMIC PROFESSIONALS			
COLOUR	Perfect Colour Perception	Able to Perceive Red, Yellow and Green				
Uncorrected Both Eyes, at least	20/100	20/100	20/200			
Corrected One Eye, at least	20/20	20/30	20/30			
Corrected Other eye, at least	20/40	20/50	20/50			
b.2 Severely impaired hearing will disqualify the applicant						
b.3 Taking age into consideration, the applicants must have normal blood pressure, and good general physical condition as found in the Clinical Evaluation.						
3. LABORATORY FINDINGS						
The Laboratory Findings must confirm satisfactory general physical conditions.						
(a) COMMENTS ON MEDICAL HISTORY AND CLINICAL EVALUATION						

REMARKS, according to Medical Requirements						
Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. Check the limiting Medical condition and List the disqualifying defect by item number.						
(a) <input type="checkbox"/>	(b) <input type="checkbox"/>	(c) <input type="checkbox"/>	defect by item number			

NAME OF EXAMINING PHYSICIAN			ADDRESS OF THE MEDICAL CENTER			
Telephone		Telex				
NAME OF MEDICAL CENTER			LICENSE NO	DATE		
Is the applicant Physically Qualified according to the Medical Requirements? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Date _____ Signature and seal of Examining Physician _____						
IMPORTANT NOTICE						
This application form shall not be considered valid for the insurance of a Certificate of Competency Examination confirmation for Merchant Marine Seafarers Aboard Panamanian Vessels, if it does not comply with any of the following requirements:						
33 The lack of address, telephone number, stamp and/or signature of the physician						
34 Incorrectly filled out or the lack of any of the laboratory tests indicated in the form						