



Vanuatu Maritime Safety Authority (VMSA)

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Port Vila

REPUBLIC OF VANUATU
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SEAFARERS MEDICAL FORM

To conform to the 1995 Amendments to the STCW convention 1978 & ISM Code

I. PERSONAL DESCRIPTION & INFORMATION

| | | | |
|---------------------------------------|------------------------------------|------------------|---|
| 01. Last Name/ Family Name / Surname | 02. First Name / Given Name | 03. Middle Name | |
| 04. Date of Birth (DD/MM/YY) | 05. Place of Birth(Island/village) | 06. Rank Grading | 07.(Sex) Male <input type="checkbox"/> Female <input type="checkbox"/> |
| 08. Permanent Address | | | |
| 09. Present Occupation | | | |
| 10. Company Which Nominated Seafarers | | | |

II. FAMILY HISTORY

| | YES | NO |
|---|--------------------------|--------------------------|
| a. Has anyone in your family or household been treated for tuberculosis(TB) in the past ten years? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you have a family history of heart disease, arthritis, rheumatism, or diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. has anyone in your family ever been treated for mental illness or 'nervous' conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| For physician's use only: Please provide further information if the answer to any of the above question is "yes". | | |
| | | |
| | | |

III. PERSONAL HISTORY

| Have you ever suffered from: | |
|---|--|
| a. tuberculosis, Spitting of blood or severe chest infection? | |
| b. conditions of the heart or lungs, including breathlessness, palpitation and high blood pressure? | |
| C. infections of the bladder, kidneys or urinary tract, including sexually transmitted infection? | |
| d. any conditions of the stomach, liver or bowels, including hepatitis or stomach ulcer? | |
| e. Convulsions, fits, epilepsy or severe migraine headaches? | |
| f. skin complaints including skin cancers, which have required medical treatment? | |
| g. malaria or leprosy- still suffer repetitive from it? still taking medication? | |
| h. diabetes, rheumatism, arthritis, hernia, stroke or cancer? | |
| i. any major accidents or recent (in the past years) surgical treatment? | |
| For physician's use only: please provide further information if the answer to any of the above questions is "yes" | |
| | |
| | |

IV. GENERAL

| | | YES | NO |
|---|----------------------------|--------------------------|--------------------------|
| a. Do you wear glasses or corrective (contact) lenses? | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. if yes, do you wear glasses for: (check one) <input type="checkbox"/> reading only <input type="checkbox"/> all the time | | | |
| 01. Last Name / Family Name /Surname | 02. First Name/ Given name | 03. Middle Name | |

Confidential- Examining medical officer's Report

I. PHYSICAL EXAMINATION

| | | |
|--|--------------------------|--------------------------|
| Candidate's general appearance: (Comment in visible signs of ill health and/ or disability) | | |
| Height: | Weight: | |
| Blood pressure: | Pulse Rate: | |
| Urinalysis: | | |
| | YES | NO |
| Is there any evidence of heart and/ or lung disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is a chest X- ray required? (Consider history as well as examination results) | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any evidence of: | | |
| Past or recent ear, nose, and /or throat infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Defect in sight or hearing (surgery tests essential) | <input type="checkbox"/> | <input type="checkbox"/> |
| Enlarged glands, varicose veins, skin lesions? | <input type="checkbox"/> | <input type="checkbox"/> |
| Conditions of the urogenital organs and tract? | <input type="checkbox"/> | <input type="checkbox"/> |
| Disease of the brain, spinal cord or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the applicant take any regular medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, name of medication and reason for taking | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Comments: | | |

II. PSYCHOLOGICAL ASSESSMENT

| | YES | NO |
|---|--------------------------|--------------------------|
| Does the applicant drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| In your opinion the applicant is a mild <input type="checkbox"/> moderate or <input type="checkbox"/> heavy drinker | | |
| Does the applicant drink kava? | <input type="checkbox"/> | <input type="checkbox"/> |
| In your opinion the applicant is a mild <input type="checkbox"/> moderate or <input type="checkbox"/> heavy drinker | | |
| Does the person have history of, or is he/she currently using drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the applicant aware that he/she may give other persons sexually transmitted disease if they have unprotected sexual encounters | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the applicant aware of the protective effects of condoms against possible health risk? | <input type="checkbox"/> | <input type="checkbox"/> |
| In your opinion, Is the applicant a mature, responsible person who will manage employment as a seafarer? | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Comments: | | |

| | | |
|------------------------------------|---------------------------|-----------------|
| 01.Last Name/ Family Name/ Surname | 02.First Name/ Given Name | 03. Middle Name |
|------------------------------------|---------------------------|-----------------|

III. MEDICAL OFFICER'S RECOMMENDATIONS

The Applicant is:

Fit for contract service for _____ years

Fit for service _____

Differed for _____ months

Rejected _____

Results of Chest X-Ray (if Done)

(the examining doctor is requested to inform the candidate whether acceptance, deferment, or rejection is recommended)

If applicant has been differed or rejected
 What further tests/investigations need to be undertaken for the candidate to be considered eligible?

Other Comments:

Medical practitioner's name:

Address:

Provide/ registration number:

Telephone _____ Fax No: _____ Email: _____

