INTEGRAL NOTES
ANNEX – D
A.O. No. 2013-0006

# NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

PASSPORT SIZE PHOTO

## MEDICAL EXAMINATION REPORT FOR SEAFARERS

**Approved and authorized by the Department Of Health (DOH) and the Maritime Industry Authority (MARINA) of the Republic of the Philippines Issued in compliance with STCW Convention, 1978, as amended Section A-I/9 Paragraph 7 and the Maritime Labour Convention, 2006**

| SURNAME/LAST NAME: | GIVEN NAME: | MIDDLE NAME: |
|---|---|---|
| AGE: | DATE OF BIRTH: DAY MONTH YEAR | PLACE OF BIRTH: CITY COUNTRY | NATIONALITY: |
| GENDER: MALE ☐ FEMALE ☐ | CIVIL STATUS: SINGLE ☐ MARRIED ☐ | RELIGION: |
| ADDRESS: | | |
| PASSPORT NUMBER: | SEAMAN'S BOOK NUMBER: | |

POSITION APPLIED FOR: DECK ☐ ENGINE ☐ CATERING ☐ OTHERS ☐ (Specify)_____

NAME OF COMPANY:

**I. MEDICAL HISTORY - Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions:**
**Place a check mark (✓) in the appropriate box ☐.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Head or Neck Injury | YES ☐ | NO ☐ | Other Lung Disorders | YES ☐ | NO ☐ | Gynaecological Disorders | YES ☐ | NO ☐ |
| Frequent Headaches | YES ☐ | NO ☐ | High Blood Pressure | YES ☐ | NO ☐ | Last Menstrual Period, specify date _____ | | |
| Frequent Dizziness | YES ☐ | NO ☐ | Heart Disease/ Vascular/ Chest Pain | YES ☐ | NO ☐ | Kidney or Bladder Disorder | YES ☐ | NO ☐ |
| Fainting Spells, Fits, Seizures or Other Neurological Disorders | YES ☐ | NO ☐ | Rheumatic Fever | YES ☐ | NO ☐ | Back Injury/Joint Pain/ Arthritis | YES ☐ | NO ☐ |
| Insomnia or Sleep Disorders | YES ☐ | NO ☐ | Diabetes Mellitues | YES ☐ | NO ☐ | Genetic, Hereditary or Familial Disorders | YES ☐ | NO ☐ |
| Depression, other Mental Disorders | YES ☐ | NO ☐ | Other Endocrine Disorders (e.g. Goiter) | YES ☐ | NO ☐ | Sexually Transmitted Diseases | YES ☐ | NO ☐ |
| Eye Problems/ Error of Refraction | YES ☐ | NO ☐ | Cancer or Tumor | YES ☐ | NO ☐ | Tropical Diseases (e g. Malaria, Typhoid Fever, specify date) | YES ☐ | NO ☐ |
| Deafness, Other Ear Disorders | YES ☐ | NO ☐ | Blood Disorders | YES ☐ | NO ☐ | Schistosomiasis (Specify date: _____) | YES ☐ | NO ☐ |
| Nose or Throat Disorders | YES ☐ | NO ☐ | Stomach Pain, Gastritis or Ulcer | YES ☐ | NO ☐ | Asthma | YES ☐ | NO ☐ |
| Tuberculosis | YES ☐ | NO ☐ | Other Abdominal Disorders | YES ☐ | NO ☐ | Allergies (Specify._____) | YES ☐ | NO ☐ |

Previous Hospitalization(s)/ Operation(s).

**Place a check mark (✓) in the appropriate box ☐.**

| | | YES | NO |
|---|---|---|---|
| 1. | Have you ever been signed off as sick or repatriated from a ship? | ☐ | ☐ |
| 2. | Have you ever been hospitalized? | ☐ | ☐ |
| 3 | Have you ever been declared unfit for sea duty? | ☐ | ☐ |
| 4 | Has your medical certificate ever been restricted or revoked? | ☐ | ☐ |
| 5. | Are you aware that you have any medical problem, disease or illness? | ☐ | ☐ |
| 6. | Do you feel healthy and fit to perform the duties of your designated position/occupation? | ☐ | ☐ |
| 7. | Are you allergic to any medication? | ☐ | ☐ |
| | Comments _____ | | |
| 8. | Are you taking any non-prescription or prescription medication? If yes, please list the medication(s) taken/being taken, and the purpose(s) and dosage(s) | ☐ | ☐ |

**II. MEDICAL EXAMINATION**
**Enter the data called for. Place a check mark (✓) in the appropriate box ☐.**

| HEIGHT (cm). | WEIGHT (kg): | BLOOD PRESSURE: Systolic:_____(mm Hg) Diastolic: _____ (mm Hg) | PULSE RATE ____/min RHYTHM: _____ | RESPIRATION: _____/min | BMI. |
|---|---|---|---|---|---|

| VISUAL ACUITY | FAR VISION | NEAR VISION | ISHIHARA COLOR VISION | EAR | Hearing by Audiometry | | CLARITY OF SPEECH |
|---|---|---|---|---|---|---|---|
| Uncorrected | OD 20/ OS 20/ | ODJ \| OSJ | Adequate ☐ | Right | ☐ Adequate | ☐ Inadequate | Adequate ☐ |
| Corrected | OD 20/ OS 20/ | ODJ \| OSJ | Defective ☐ | Left | ☐ Adequate | ☐ Inadequate | Defective ☐ |

**II. MEDICAL EXAMINATION (Continuation). Alongside columns A, B, C, put a check mark (✓) under 'YES' if Normal. If not Normal, specify findings.**

| A | YES | Significant Findings | B | YES | Significant Findings | C | YES | Significant Findings |
|---|---|---|---|---|---|---|---|---|
| Skin | ☐ | | Neck, Lymph Nodes, Thyroid | ☐ | | Genito-urinary System | ☐ | |
| Head, neck, scalp | ☐ | | Chest-Breast-Axilla | ☐ | | Inguinals, Genitals | ☐ | |
| Eyes, external | ☐ | | Lungs | ☐ | | Extremities | ☐ | |
| Pupils, Ophthalmoscopic | ☐ | | Heart | ☐ | | Reflexes | ☐ | |
| Ears | ☐ | | Abdomen | ☐ | | Dental (Teeth/Gums) | ☐ | |
| Nose, Sinuses | ☐ | | Back | ☐ | | | | |
| Mouth, Throat | ☐ | | Anus-rectum | ☐ | | | | |

**III. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (✓) in the appropriate box ☐.**

| | | |
|---|---|---|
| A CHEST X-RAY ☐ Normal ☐ With Findings | D. URINALYSIS. ☐ Normal ☐ With Findings | G. HIV/AIDS Test. ☐ Reactive ☐ Non-Reactive (when required) |
| B. ECG: ☐ Normal ☐ With Findings | E STOOL EXAM. ☐ Normal ☐ With Findings | H RPR and/or TPHA ☐ Reactive ☐ Non-Reactive |
| C CBC: ☐ Normal ☐ With Findings | F. Hepatitis B: (when required) ☐ Reactive ☐ Non-Reactive | I BLOOD TYPE (Specify): |

PSYCHOLOGICAL TEST (when required): ☐ Normal ☐ For Further Evaluation

ADDITIONAL TEST(S) (Specify). e.g. Blood Chemistries, Drug Test, Alcohol Test, Liver Function Test, Stool Culture, etc.

**IV. SUMMARY. Place a check mark (✓) in the appropriate box ☐.**

| | | |
|---|---|---|
| Basic DOH Mandatory Medical Examination | ☐ PASSED | ☐ WITH SIGNIFICANT FINDINGS |
| Additional Laboratory Tests. | ☐ PASSED | ☐ WITH SIGNIFICANT FINDINGS |
| Flag/Host Medical and Laboratory Requirements | ☐ PASSED | ☐ WITH SIGNIFICANT FINDINGS |

**REMARKS/SPECIAL NEEDS (Sspecify e.g. with medication, diet restriction etc.)**

**V. ASSESSMENT OF FITNESS FOR SERVICE AT SEA. Place a check mark (✓) in the appropriate box ☐.**

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically.

**FIT FOR LOOK-OUT DUTY** ☐ **NOT FIT FOR LOOK-OUT DUTY** ☐

| | DECK SERVICE | ENGINE SERVICE | CATERING SERVICE | OTHER SERVICES |
|---|---|---|---|---|
| FIT | ☐ | ☐ | ☐ | ☐ |
| UNFIT | ☐ | ☐ | ☐ | ☐ |

**WITH RESTRICTIONS:** ☐ **WITHOUT RESTRICTIONS:** ☐ **VISUAL AIDS REQUIRED:** YES ☐ NO ☐

Describe restrictions** (refer to standard restrictions at the bottom of this page).

_____

| DATE OF MEDICAL EXAMINATION: | DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: | MEDICAL EXAMINATION REPORT NO: |
|---|---|---|
| DAY MONTH YEAR | DAY MONTH YEAR | |

**NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN:** _____

**LICENSE NUMBER:** _____

**ADDRESS:** _____

I hereby certify that the personal declaration above is true to the best of my knowledge and I fully understand the above results of my medical examination as explained to me by the examining/authorized physician.

I hereby authorize the release of all my medical records to the DOH/MARINA/POEA, the examining/authorized physician and my employer/manning agency (_____).

_____ _____

**NAME AND SIGNATURE OF SEAFARER** **DATE**

**THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN**

***STANDARD RESTRICTIONS (Duties)***

- *No solo watchkeeping*
- *Not fit for emergency duties*
- *Not fit for lookout duties*
- *Only fit for lookout during daylight hours*
- *Not fit for work with colour coded tables etc*
- *Not to be away from (home) port overnight*
- *Not to be away from (home) port for periods over 24 hours/7days*
- *Not to lift items weighing over 5/10/20/40kg*
- *Protective gloves to be worn for work with (specify)*
- *Eye protection to be worn for all work*
- *Not to work with (specify)*
- *Not fit for food handling*
- *Within (specify) miles from a safe haven*
- *Near – coastal only*
- *Coastal waters only, up to (specify) miles from shore*
- *Non-tropical waters only*
- *Not fit for service on stand-by vessels*
- *Fit for service only on vessels with ship's doctor*
- *Toilet/washing facilities in private cabin required*
- *Special needs in emergencies (specify)*

# SPECIFICATIONS OF AND INSTRUCTIONS ON HOW TO ACCOMPLISH THE "MEDICAL EXAMINATION REPORT (MER) FOR SEAFARERS"

1. Use only size A4 bond paper with a MINIMUM of substance 20.
2. Use only one (1) sheet of bond paper with the following back to back information:
   a. FRONT PAGE – contains the following:
      1. Personal Information of the Seafarer;
      2. Medical History;
      3. Medical Examination.
   b. BACK PAGE – contains the following:
      1. Continuation of the Medical Examination;
      2. Results of Ancillary Examinations;
      3. Summary of the Medical Examination Report;
      4. Assessment of Fitness for Service at Sea.
3. Use English language until further orders from the Department of Health.
4. Use only black ink.
5. Use only white background.
6. The applicant's photo, passport size, shall be digitized and located at the right upper corner of the front page.
7. The Official Stamp or Clinic Logo may be in color but the clinic name and information must be in black.
8. Security features are allowed.
9. Kindly put a check mark (✓)on the appropriate box ☐and enter all data called for. Do not leave any item blank.
10. The seafarer shall affix his signature in the presence of the examining physician.
11. The signature of the examining physician shall be original and/or in accordance with the E-Commerce Law.
12. The MER stays with the medical clinic where PEME was conducted. A principal/ employer in need of further medical information contained in the MER shall make a formal request addressed to the head of the clinic.

Approved by:

**ATTY. NICOLAS B. LUTERO III, CESO III**
Assistant Secretary
Department of Health