

Medical Examination Form for STCW or STCW-F Seafarers

IMPORTANT

This form is for **Approved Medical Practitioners** who are examining seafarers that have STCW or STCW-F maritime certificates. Medicals for National or Ring-fenced seafarers do not require completion of any form.

Section 1: Seafarer declaration

Surname: _____

First name(s): _____

Date of birth:
(day/month/year): _____

Gender:

Male

Female

Home address: _____

Identity document type: _____

No.: _____

Type of ship (eg container, tanker, passenger, fishing): _____

Trade area (eg inshore, coastal, unlimited): _____

Examinee's personal declaration (Assistance should be offered by medical staff)

Condition	Yes	No	Condition	Yes	No
1. Eye/vision problem	<input type="checkbox"/>	<input type="checkbox"/>	18. Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	19. Smoker	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart/vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	20. Operation/surgery	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	21. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	22. Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	23. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
7. Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	24. Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	25. Depression	<input type="checkbox"/>	<input type="checkbox"/>
9. Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	26. Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
10. Digestive disorder	<input type="checkbox"/>	<input type="checkbox"/>	27. Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
11. Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	28. Balance problem	<input type="checkbox"/>	<input type="checkbox"/>
12. Skin problem	<input type="checkbox"/>	<input type="checkbox"/>	29. Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	30. Ear/nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>
14. Infectious/contagious diseases	<input type="checkbox"/>	<input type="checkbox"/>	31. Restricted mobility	<input type="checkbox"/>	<input type="checkbox"/>
15. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	32. Back problems	<input type="checkbox"/>	<input type="checkbox"/>
16. Genital disorders	<input type="checkbox"/>	<input type="checkbox"/>	33. Amputation	<input type="checkbox"/>	<input type="checkbox"/>
17. Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	34. Fractures/dislocations	<input type="checkbox"/>	<input type="checkbox"/>

If any of the personal declaration questions were answered “yes”, please give details below:

Additional questions

	Yes	No
35. Have you ever been signed off as sick or repatriated from a ship?	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you ever been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>
37. Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input type="checkbox"/>
38. Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
39. Are you aware of having any medical problems, diseases or illness?	<input type="checkbox"/>	<input type="checkbox"/>
40. Do you feel healthy and fit to perform the duties of your designated position/occupation?	<input type="checkbox"/>	<input type="checkbox"/>
41. Are you aware of being allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

	Yes	No
42. Are you taking any prescription or non-prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please list the medications taken and the purpose(s) and dosage(s):

Seafarers should note that under Rule 34.22(2) they should supply their vaccination record to the approved medical practitioner if applying for an “unlimited areas” certificate.

NOTE

This does not need to be sent to Maritime NZ. The CERTIFICATE of Medical Fitness – STCW or STCW-F Seafarers must be submitted to Maritime NZ.

Seafarers must complete Section 1 of the form. The Doctor will complete Section 2.

I hereby certify that the personal declaration above is a true statement to the best of my knowledge:

Signature of examinee: _____ Date (day/month/year): / / _____

Witnessed by: _____ Name: _____
Signature *Typed or printed name*

I hereby authorise the release of all my previous medical records from any health professionals, health institutions and public authorities to:

Dr: _____ *(the approved medical practitioner)*

Signature of examinee: _____ Date (day/month/year): / / _____

Witnessed by: _____ Name: _____
Signature *Typed or printed name*

Privacy protection

The information collected on this form is protected by the provisions of the Privacy Act 2020 and the Health Information Privacy Code 2020. The information is collected for the purpose of an approved medical practitioner determining the applicant’s fitness for intended work as a seafarer. The collection of the information is required by Maritime Rules Part 34 made under the maritime Transport Act 1994. Failure to provide the information required may result in a failure to pass the medical examination. The applicant has the right of access to, and correction of, any personal information contained on this form.

Section 2: Medical examination

Pre-sea Periodic Other (please specify): _____

	Visual acuity					
	Unaided			Aided		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant						
Near						

	Visual fields	
	Normal	Defective
Right eye		
Left eye		

Colour vision: Not tested Normal Doubtful Defective

	Hearing <i>Pure tone and audiometry (threshold values in dB)</i>					
	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right ear						
Left ear						

	Speech and whisper test (metres)	
	Normal	Whisper
Right ear		
Left ear		

Section 3: Assessment of fitness for service at sea

On the basis of the examinee's personal declaration, my clinical examination, and diagnostic test results recorded on the medical examination form, I declare the examinee's medical category under Maritime Rule Part 34.25(2) is:

(Medical category letter)

(Medical category explained in text)

Describe restrictions (eg specific position, type of ship, trade area)

I confirm that:

- hearing and sight are satisfactory for duties in the capacity of: _____
- he/she* is fit/not fit* for lookout duties (deck department only): _____

Action taken by approved medical practitioner (eg referral):

Place of examination: _____ Date of examination (day/month/year): ____ / ____ / ____

Medical certificate's date of expiration (day/month/year): ____ / ____ / ____

Official stamp (also print name of approved medical practitioner if not legible):

Signature of approved medical practitioner:

MCNZ ID: (Medical Council
New Zealand ID)

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