THE REPUBLIC OF TRINIDAD AND TOBAGO
MARITIME SERVICES DIVISION

MEDICAL FITNESS CERTIFICATE

Issued under the Shipping (Medical Examination) Regulations, 1990

Seafarer's Name ..... Discharge Book No. .....

Date of expiry of this Certificate.....

I certify that I have examined the seafarer named above to the Medical and Visual Standards of Trinidad and Tobago as contained in the Third and Fourth Schedules of the above-named Regulations and have found *him/her fit for seafaring subject to the following restrictions:

Signed.....
(A registered medical practitioner approved by the Minister)

Date of Examination.....

Official Stamp

*Delete as appropriate

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In Confidence

RECORD OF MEDICAL EXAMINATION OF SEAFARERS

REPORT OF MEDICAL EXAMINATION BY AN APPROVED MEDICAL PRACTITIONER

1. Personal Details of Seafarer

Surname.....

Forenames.....

Discharge Book No.....

Tick correct box

Title Mr.☐ Mrs.☐ Miss☐ Ms.☐

Any other title held.....

Date of Birth.....

day month year

Rank/Rating/Occupation.....

2. Usual Medical Practitioner or Medical Adviser?

Name.....

Address .....

3. Family Medical History

Has any member of the seafarer's family ever suffered from:

Please tick correct box

	Yes	No
Hypertension	☐	☐
Heart Condition	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Mental Disorder	☐	☐
Epilepsy	☐	☐

4. Previous Medical History

Does the seafarer have a medical history of one of the following? If so (please tick the box).

Hypertension	☐
Eye trouble/squint	☐
Stomach/bowel disorder	☐
ENT	☐
Hearing impaired	☐
Skin disease/allergies	☐
Heart condition/rheumatic fever	☐
Asthma/bronchitis	☐
Hay fever/allergies	☐
Epilepsy/fits/fainting	☐
Nervous/mental illness	☐
Jaundice/liver disease/piles	☐
Urinary disorders	☐
Back injury/pain	☐
Hernia	☐
Diabetes	☐
Female disorders	☐
Infectious/contagious/tropical diseases	☐
Malignant diseases	☐
Migraine/severe headaches	☐
Head injury/concussion	☐
Abnormal weight change	☐
Sexually transmitted diseases	☐
AIDS	☐

Tobacco intake (quantity).....

Alcohol intake(quantity).....

Other illnesses/operations

Is the seafarer now receiving any treatment?.....

I certify that this is a true statement

Signature of Seaman.....

L.R.O.

5. Medical Examination

Does the seafarer suffer from any of the following abnormalities?

Please tick correct box and expand as necessary

Tooth	☐
ENT	☐
Skin	☐
Heart	☐
Lungs	☐
Nervous system	☐
Varicose veins	☐
Genito urinary system	☐
Hernia	☐

Any other defects.....

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6 Height (without shoes).....m .....cm

Weight (stripped to waist).....kilos

Chest Inspiration .....cm

Expiration.....cm

Pulse rate.....

Eye test

Blood pressure systolic.....

5th Sound.....

Results of urine test

Albumim.....

Sugar.....

Audiogram (if equipment is available)

Right ear

KhZ dB	500	1,000	2,000	4,000	6,000	6,000

Left ear

KhZ dB	500	1,000	2,000	4,000	6,000	8,000

Distant vision

Unaided Aided	R 6 R 6		L 6 L 6		Both 6 Both 6	

Near vision

Unaided N
Aided N

Colour visic

Ishihare Engineers modified	
Normal	Defect

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7. Results of Medical Examination

The Standards of Medical Examination Regulations have been or have not been met.

Tick correct box

A	Unrestrictive sea service	☐	D	Indefinitely	☐
B	Restriction service only	☐		(Review in.....months)	
Restriction.....			E	Permanently	☐
Period of restriction.....					
C	Temporarily	☐			
	(Review in.....months)				

Medical Practitioner's Official Stamp

Signature.....

Name.....

Block

Date.....