



HAQUE & SONS LTD.



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Accredited By : BMDC
Accreditation No. A 22539

PATIENT CONTROL NUMBER:
H394

MEDICAL EXAMINATION CERTIFICATE

SURNAME KARMAKER	FIRST NAME TONY	MIDDLE NAME
PLACE AND DATE OF BIRTH CHITTAGONG 1-Jan-1987	PASSPORT NUMBER B00084804	SEAMAN'S BOOK NUMBER CO4953
NATIONALITY : BANGLADESHI SEX : Male Female	VESSEL TYPE : CHEM. TANKER TRADING AREA : WORLD WIDE	
PERMANENT HOME ADDRESS : VILL: MOGADIA, P.O: ABUTORAB, P.S. MIRSHARAI, CHITTAGONG.	CONTACT NUMBER : 01815-506892 (FATHER)	RANK : TR.CHIEF OFFICER

Have you ever had any of the following conditions?

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

If any of the above questions were answered "yes", please give details.

Additional questions

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

Comments:

Fit For Duty on Board Ship

42 Are you taking any non-prescription or prescription medications? YES NO
If yes, please list the medications taken and the purpose(s) and dosage(s)

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. Md Rafiqul Islam (approved medical practitioner). I also certify that my history contained above is true and any false statement will disqualify me from my employment, benefits and claims.

Tony Kar

Signature of Seafarer

MEDICAL EXAMINATION

Weight *68kg* Height (cm) *172* BM *23.5* Blood Pressure: Systolic *120* Diastolic *80* PULSE: *72*

Ear	Hearing by Audiometry	
Right	<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
Left	<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate

Audiometry			
500	1000	2000	3000

Hearing by Whisper Test	
<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate
<input checked="" type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate

Hearing meets the standards as laid down in STCW Code Section A-1/9 ? YES NO

Visual acuity					Visual fields	
	Unaided		Aided			
	Right eye	Left eye	Right eye	Left eye		
Distant	6/6	6/6			Right eye	/
Near	N/20	N/20			Left eye	/

Visual acuity meets the standard laid down in STCW Code Section A-1/9
 Colour vision as per STCW CODE Section A-1/9: Normal Doubtful Defective

Date of last colour vision test: Date (day/month/year) _____ **13 SEP 2022**

	Normal	Abnormal		Normal	Abnormal
Head	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses, nose, throat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Vascular (inc. pedal pulses)	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/teeth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	<input type="checkbox"/>	<input type="checkbox"/>
Ears (general)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Tympanic membrane	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Anus (not rectal exam)	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	G-U system	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmoscopy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Upper and lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Pupils	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Spine (C/S, T/S and L/S)	<input type="checkbox"/>	<input type="checkbox"/>
Eye movement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neurologic (full brief)	<input type="checkbox"/>	<input type="checkbox"/>
Lungs and chest	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Breast examination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	General appearance	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Skin	<input checked="" type="checkbox"/>	<input type="checkbox"/>

RESULTS OF ANCILLARY EXAMINATIONS					
Chest X-Ray	N/20	BIO CHEMICAL (LIVER FUNCTION TEST)	Marijuana	<input type="checkbox"/> Positive	<input checked="" type="checkbox"/> Negative
ECG	4	BILIRUBIN	Alcohol Test	<input type="checkbox"/> Positive	<input checked="" type="checkbox"/> Negative
	BLOOD R/E	SGPT	URINE R/E	OTHERS	
DC(differential count)	N/20	SGOT			
HAEMOGLOBIN (HGB)	4	DRUG AND ALCOHOL TEST		HBsAg	<input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Nonreactive
ESR (WESTERGREN)	4	Morphine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	HIV / AIDS Test	<input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Nonreactive
WBC	4	Amphetamine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	VDRL	<input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Nonreactive
	BLOOD GLUCOSE LEVEL	Phencyclidine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Blood Type	AB501
RANDOM	N/20	Barbiturates	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Psychological Exam	N/20
HBA1C	4	Cocaine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Others(KUB Ultraso	4

Hereby I declare that I am in knowledge of the contents of the Physical examinations:

13 SEP 2022

Signature of Seafarer: _____ Name of Seafarer: **TONEY KARMAKER** Date: _____

Assessment of fitness for service at sea:
 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 lookout duties Not fit for lookout duties

	Deck service	Engine service	Catering service	Other services
Fit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unfit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Without restrictions With restrictions

Is the Seafarer free from any medical conditions likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board?

Yes No

Describe restrictions (e.g., specific position, type of ship, trade area):

Action taken by medical examiner (e.g., referral):

Fitness Date: **13 SEP 2022** Valid Until: **12 SEP 2024**

Name and Signature of Authorized Physician: _____
Dr. Md. Rafiqul Islam, M.D. (Part-1)
 Approved by: _____
 Regd No: _____