



# HAQUE & SONS LTD.



Rumman Haque Tower, 1267/A, Goshaldanga, Agrabad C/A, Chattogram, Bangladesh.  
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Accredited By : BMDC  
Accreditation No. A 22539

PATIENT CONTROL NUMBER:  
H169

## MEDICAL EXAMINATION CERTIFICATE

SURNAME <b>UDDIN</b>	FIRST NAME <b>IMAD</b>	MIDDLE NAME
PLACE AND DATE OF BIRTH <b>FENI 1-Oct-1990</b>	PASSPORT NUMBER <b>A04949408</b>	SEAMAN'S BOOK NUMBER <b>CO6046</b>
NATIONALITY : <b>BANGLADESH</b> SEX : Male Female		VESSEL TYPE : <b>CHEM. TANKER</b> TRADING AREA : <b>WORLD WIDE</b>
PERMANENT HOME ADDRESS : <b>C/O ABU AHAMMAD, ABDUL MAZI BARI, VILL. CHAR KHOAZ, P.O. SONAGAZI, P.S. SONAGAZI, DIST. FENI, BANGLADESH.</b>		CONTACT NUMBER : <b>01811-936009 (SELF)/0182</b>
		RANK : <b>1ST ASST ENGINEER</b>

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

Question	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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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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.

*[Signature]*

Signature of Seafarer

### MEDICAL EXAMINATION

Weight *74kg* Height (cm) *170* BM *25.6* Blood Pressure: Systolic- *115.4* Diastolic *75.4* PULSE: *72*

Ear	Hearing by Audiometry		Audiometry				Hearing by Whisper Test	
	Right	Left	500	1000	2000	3000	Adequate	Inadequate
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

