



HAQUE & SONS LTD.



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

PATIENT CONTROL NUMBER:
H171



MEDICAL EXAMINATION CERTIFICATE

SANY	FIRST NAME REASON PRASHAD	MIDDLE NAME BARUA
DATE OF BIRTH 24-Oct-1988	PASSPORT NUMBER BY0493554	SEAMAN'S BOOK NUMBER CO6072
NATIONALITY : BANGLADESHI SEX : Male Female		VESSEL TYPE : CHEM. TANKER TRADING AREA : WORLD WIDE
PERMANENT HOME ADDRESS : VILL. ABURKHIL (TALUKDAR PARA), P.O. GUJARA (B.O.), P.S. RAOJAN, DIST. CHITTAGONG.		CONTACT NUMBER : 01819-806479
		RANK : 2ND ASST ENGINEER

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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 practioner) 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 <i>75kg</i>	Height (cm) <i>183</i>	BM <i>22.5</i>	Blood Pressure: Systolic- <i>115</i> Diastolic <i>75</i>	PULSE: <i>72</i>
Ear	Hearing by Audiometry	Audiometry		Hearing by Whisper Test
Right	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate	500	1000	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
Left	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate	<i>N/A</i>		<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
Hearing meets the standards as laid down in STCW Code Section A-1/9 ? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				

Visual acuity					Visual fields	
	Unaided		Aided		Right eye	Left eye
	Right eye	Left eye	Right eye	Left eye		
Distant	6/6	6/6			/	
Near	10/10	10/10			/	

Visual acuity meets the standard laid down in STCW Code Section A-1/9 YES / NO NO

Colour vision as per STCW CODE Section A-1/9: Normal Doubtful Defective

Date of last colour vision test: Date (day/month/year) 10 NOV 2022

	Normal	Abnormal		Normal	Abnormal
Head	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sinuses, nose, throat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Vascular (inc. pedal pulses)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mouth/teeth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ears (general)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hernia	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Tympanic membrane	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Anus (not rectal exam)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Eyes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	G-U system	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ophthalmoscopy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Upper and lower extremities	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pupils	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Spine (C/S, T/S and L/S)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Eye movement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neurologic (full brief)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lungs and chest	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Breast examination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	General appearance	<input checked="" 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	<u>Nil</u>	BIO CHEMICAL (LIVER FUNCTION TEST)		Marijuana	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative
ECG	<u>✓</u>	BILIRUBIN	<u>Nil</u>	Alcohol Test	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative
BLOOD R/E		SGPT	<u>✓</u>	URINE R/E	<u>Nil</u>
DC (differential count)	<u>Nil</u>	SGOT	<u>✓</u>	OTHERS	
HAEMOGLOBIN (HGB)	<u>✓</u>	DRUG AND ALCOHOL TEST		HBsAg	<input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Nonreactive
ESR (WESTERGREIN)	<u>✓</u>	Morphine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	HIV / AIDS Test	<input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Nonreactive
WBC	<u>11</u>	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	<u>AB+ve</u>
RANDOM	<u>Nil</u>	Barbiturates	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Psychological Exam	<u>Nil</u>
HBA1C	<u>✓</u>	Cocaine	<input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative	Others (KUB Ultrasound)	<u>✓</u>

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

[Signature]
Signature of Seafarer
REASON PRASHAD BARUA SANY
Name of Seafarer
10 NOV 2022
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 type="checkbox"/>	<input checked="" 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: 10 NOV 2022 Valid Until: _____

[Signature]
Name and Signature of Authorized Physician