



Australian Government

Australian Maritime Safety Authority

MEDICAL EXAMINATION REPORT

PART A—TO BE COMPLETED BY APPLICANT

You should complete this section before you go for your medical examination.

You must take a suitable means of identification (passport, certificate of competency, Australian driving licence) with you to the examination.

Name

Family name
Given name(s)

Seafarer I.D.

Date of birth

dd / mm / yyyy

Male Female Indeterminate

Permanent address

Email address

Department/Position on board vessel

Deck

Master/Deck Officer/Pilot Able Seafarer Deck

Seafarer forming part of a navigation watch

Engineering

Engineer Officer*/Electro-technical Officer

Able Seafarer Engine* Engine Room Rating*

Seafarer forming part of an engine room watch*

Integrated Rating*

Catering

Marine Cook* Catering* Other*

Other (specify) _____

* Denotes Hepatitis A arrangements apply

Personal history

Are you in good health now? Yes No

Doctors Comments

Do you drink alcohol? Yes No

If yes, how much and how often?

Doctors Comments

PRIVACY NOTE

The Australian Maritime Safety Authority (AMSA) is collecting the information on this form for the purpose of assessing your medical fitness for duty at sea and for AMSA audit purposes. The collection of the information is required, authorised or directly related to the *Navigation Act 2012* (the Act) and the marine orders made under it. It will be used for purposes related to the Act and marine orders and will be treated in accordance with the Australian Privacy Principles. This information may be exchanged between AMSA, your examining medical officer, your treating medical practitioner and/or any medical panel convened to assess your fitness for duty at sea. Failure to provide the information may result in the transaction not being processed. To contact us, or for more information on how to access or correct your personal information, how to make a privacy complaint, or how your information may be used or disclosed, visit AMSA's privacy policy at www.amsa.gov.au/privacy

Have you ever used illicit drugs? Yes No

If yes, Doctor must comment

Do you smoke tobacco? Yes No

If no, have you smoked in the past? Yes No

If yes, Doctor must comment

Have you been absent from work due to sickness or injury for more than 14 consecutive days over past two years?

Yes No

If yes, give details

If yes, Doctor must comment

Have you ever had any surgical or chiropractic treatment?

Yes No

If yes, give details

If yes, Doctor must comment

Are you taking any medications at present? Yes No

If yes, Doctor must comment - Record all medications

Do you have or have you had any eye disorder or injury? Yes No

If yes, Doctor must comment

NOTE: If you wear glasses, corneal or contact lenses, bring them with you to the examination. CHROMAGEN LENSES MUST NOT BE WORN

Have you ever been declared unfit for duty at sea? Yes No

If yes, state when, for how long and for what reason

If yes, Doctor must comment

Has your Certificate of Medical Fitness ever been restricted or cancelled? Yes No

If yes, give details

If yes, Doctor must comment

Have you now, or have you previously had any of the following:

- Psychological or psychiatric disorder
- Anxiety or depression
- Migraine or persistent headaches
- Epilepsy or fits
- Poliomyelitis or other paralysis
- Attack of unconsciousness or weakness, dizziness or turns
- Any other neurologic condition Yes No

If yes, Doctor must comment

- High blood pressure
- Disease of the heart, arteries or blood vessels
- Operation on the heart
- Anaemia or any other disease of the blood
- Swelling of the ankles
- Palpitations
- Varicose veins or abnormal bleeding
- Rheumatic fever
- Any other cardiovascular condition Yes No

If yes, Doctor must comment

- Asthma
- Bronchitis or emphysema
- Tuberculosis
- Persistent breathlessness
- Persistent cough
- Collapsed lung
- Other lung disease/abnormal x-ray
- Any other lung disease or condition Yes No

If yes, Doctor must comment

- Disease of the liver (including jaundice or hepatitis)
- Disease or ulcer of the stomach or duodenum
- Recurrent abdominal pain/persistent indigestion
- Appendicitis
- Gallbladder disease
- Disease of the bowels
- Haemorrhoids (piles)
- Hernia (rupture)
- Recent change in weight
- Any other gastrointestinal condition Yes No

If yes, Doctor must comment

- Infection of bladder
- Kidney disease or kidney stone
- Difficulty in passing urine
- Any abnormality of the urine
- Sexually transmitted disease
- Any other genital or urinary conditions Yes No

If yes, Doctor must comment

- Lumbago, sciatica or other back trouble
- Any form of arthritis or stiff joints
- Slipped discs or back or neck pain
- Joint injuries
- Injury of the neck or back
- Repetitive Strain Injury, tennis elbow, tendonitis
- Broken bones
- Gout
- Any other musculoskeletal conditions Yes No

If yes, Doctor must comment

- Discharge from ears or perforated eardrum
- Ringing in the ears or disturbances of balance
- Deafness
- Nasal or sinus trouble
- Persistent husky voice or frequent sore throat
- Goitre or Thyroid disease Yes No

If yes, Doctor must comment

- Any form of cancer or unexplained lumps Yes No

If yes, Doctor must comment

- Diabetes Yes No
- Adrenal disease Yes No

If yes, Doctor must comment

- Dermatitis/eczema/skin eruptions
- Allergy conditions including hay fever
- Any abnormality of the immune system Yes No

If yes, Doctor must comment

- Any allergic reaction to any serum, drug or medicine (including anaesthetic agents) and vaccines Yes No

If yes, Doctor must comment and include type of reaction

- Any diseases such as malaria, typhoid, amoebiasis, giardia etc Yes No

If yes, Doctor must comment

- Severe tooth or gum trouble Yes No
- Impacted wisdom teeth Yes No

If yes, Doctor must comment

- Any obstetric or gynaecological problems Yes No

If yes, Doctor must comment

• Are you pregnant? Yes No

If yes, Doctor must comment

Please give details of any complaint, illness or injury not previously mentioned

[Empty box for details of complaint, illness or injury]

The following should be signed in the presence of the examining medical inspector

Warning: Giving false or misleading information is a serious criminal offence and may lead to prosecution

Are you aware of ANY circumstances regarding your health which may interfere with the satisfactory discharge of the duties of your designated position/occupation? Yes No

If yes, give details

Declaration

I hereby declare that, to the best of my knowledge my personal statements are true and correct

Applicant's signature Date/...../20.....

Authority to divulge medical information

If, as a result of this or subsequent examinations for the purposes of assessing my medical fitness for duty at sea, the examining Medical Inspector requires relevant medical details from my treating medical advisor(s), permission is hereby granted to obtain information from:

Dr Address and phone
(Current General Practitioner)

.....

Dr Address and phone

.....

Dr Address and phone

.....

Applicant's signature Date/...../20.....

PART B – TO BE COMPLETED BY MEDICAL INSPECTOR

Please refer to the 'Standards for the medical examination of seafarers and coastal pilots' available at www.amsa.gov.au/standards-medical-examination

Medical Inspector's name

Telephone number

Applicant's proof of identity

Passport

Photo driver's licence

Other

Passport/Driving Licence No.

Applicant's position on board vessel

Requirements regarding hepatitis, colour vision etc will depend on the applicant's position on board the vessel. Refer to the Standards for the medical examinations of seafarers and coastal pilots.

HEIGHT/WEIGHT

(Standards—page 8)

Height (without shoes)..... metres

Weight kg

Weight in kg

Body Mass Index (BMI) = $\frac{\text{Weight in kg}}{(\text{Height in m})^2}$

Is the applicant able to:

- Move safely around vessel and safely move through hatches Yes No
- Move quickly in an emergency situation Yes No
- If no, is a functional assessment required Yes No

VISION

(Standards—page 9)

The visual acuity of each eye should be tested with Snellen's Charts, and the results recorded. Both unaided and aided (if applicable) must be recorded.

Visual acuity

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

Visual fields to confrontation

	Normal	Defective
Right eye		
Left eye		

Does the applicant meet the medical standards for his/her work category? Yes No

Colour vision

Colour vision must be tested by Ishihara Plates at EACH medical assessment.

Ishihara test Pass Further testing needed

Number of plates shown

Number of plates with errors

Does the applicant suffer from any degree of colour blindness as determined by Ishihara plates? Yes No

If the Ishihara test has 3 or more errors (24 page edition) or 4 or more errors (38 page edition) further testing is required for the deck or engine department, if not completed within the previous 6 years. Any previous reports must be sighted by the MIS and a copy attached to the medical examination report.

Date of last Lantern or Farnworth D15 colour vision test if **not** tested at this examination

 / /

Lantern test (Deck dept. only) Yes No Not required

Farnsworth D15 Test (Engine dept. only) Yes No Not required

Applicant considered colour safe for position on board? Yes No

SPEECH / HEARING / BALANCE

(Standards—page 11)

Is there any defect in speech? Yes No

Is there any disease of the ears? Yes No

Is there any defect in hearing? Yes No

Romberg's test normal? Yes No

Pure tone and audiometry (threshold values in dB)

	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz
Right ear						
Left ear						

Conversation Test at 3 metres

Conversation test only required if hearing loss in the better ear is more than 40 dB at 500 to 3000 Hz

	Speech
Both ears together	/10

Doctor comments

CARDIOVASCULAR (Standards—page 12)

Pulse:/min Rhythm

Blood Pressure readings: Systolic Diastolic

- If this reading is above 150/95 please take further readings after rest.

Systolic Diastolic

Heart sounds / apex beat Normal Abnormal

Is there any history or evidence of taking anti-hypertensive medication? Yes No

ECG Report (Attach report and tracing to this form).
(Stress ECG required if clinically indicated. Baseline tracing only to be attached to this document.)

Date of ECG: / /

ECG results

Stress ECG result (if clinically indicated)

Does the applicant suffer from oedema or varicose veins? Yes No

If yes, state severity

Are carotid / peripheral pulses normal? Yes No

Are you satisfied that the cardiovascular system is clinically within normal limits? Yes No

If no, give reasons in full

RESPIRATORY (Standards—page 14)

Trachea Midline Abnormal

Chest expansion cm Abnormal

Breath sounds Normal Abnormal

Spirometry

	Actual	Predicted	% Predicted
FEV ₁			
FVC			
FEV ₁ /FVC			

Spirometry FEV₁ < 65% requires further review
FVC < 70% requires review
FEV₁/FVC < 70% requires review

Chest X-ray report Normal Abnormal

(Chest X-rays are required for pre-sea medicals or if clinically indicated.)
Date / / 20
(Attach report to this form)

If, after examination you are not satisfied with the clinical condition and efficiency of the respiratory system and chest give reasons

Reasons

MOUTH / TEETH (Standards—page 15)

Is there any disease or abnormality of the mouth, throat or neck? Yes No

Are there any defects in teeth? Yes No

Is there any disease of the nose or sinuses? Yes No

Details of any abnormalities

GASTROINTESTINAL / RENAL (Standards—page 15)

Is there any disease or abnormality of the abdominal organs? Yes No

Is there any hernia present? Yes No

Is the liver enlarged? Yes No

Urine dipstick results Glucose Normal Abnormal

Protein Normal Abnormal

Blood Normal Abnormal

Other

If yes, give details

Hepatitis A arrangements

Does the applicant have active immunity to Hepatitis A (completed vaccination course or evidence of past infection)? Yes No

If **yes**, date of last vaccination / /

or date of Antibody Positive blood test / /

If **no**, was Hepatitis A vaccination provided on this occasion? Yes No

If no, please provide reason

Hepatitis A arrangements apply to applicants who have a position on board marked with an * on the front page of this form.

NEUROLOGICAL / PSYCHIATRIC (Standards – pages 17 & 19)

Is there any evidence of organic disease of the brain, spinal cord or nerves? Yes No

Is there any evidence of mental or nervous disorder including psychoses? Yes No

Is there any evidence suggestive of anxiety, panic disorder or personality disorder? Yes No

If yes, give details

MUSCULOSKELETAL (Standards—page 21)

- Does the applicant have normal use of the legs and arms? Yes No
- Are there any missing limbs or digits? Yes No
- Is gait normal? Yes No
- Are the bones and joints free of any defects? Yes No
- Are joint movements in normal range and pain free? Yes No
- Any restriction or pain in movement of spine? Yes No

If yes, give details

SKIN / LYMPH NODES (Standards—page 23)

- Is there any skin disease, including solar keratoses, BCCs, eczema etc? Yes No
- Are there any significant scars, ulcers, or enlarged lymph nodes? Yes No
- Are there any skin grafts? Yes No
- Are there any identifying marks on the skin? Yes No

If yes, give details

Period of review

- Under 18/over 55 - 1 year 18 to 55 - 2 years Other*

*If period of review is "other", state period and reason.

Medical Inspector's signature

Date

ATTACH ALL TEST DOCUMENTS TO THIS REPORT

- **CHEST X-RAY REPORT**
(for pre-sea medicals or if clinically indicated)
- **ECG TRACING**
(for applicants aged 55 years or more and/or if clinically indicated)
- **ECG REPORT**
(confirmed automatic machine report, or report by FRACGP or appropriate specialist)
- **STRESS ECG**
(if clinically indicated)
- **AUDIOGRAM REPORT**
(if clinically indicated)

Original copy of this report is to be forwarded by the Medical Inspector to Sonic HealthPlus Seafarer Admin Team after the examination is completed.

The Medical Inspector should retain a copy for record purposes for a period of at least 30 years.

A copy may be given to the applicant for his/her records if requested.