



MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD REPUBLIC OF PANAMA

SURNAME:		GIVEN NAME (S):	
DATE OF BIRTH: DAY MONTH YEAR		PLACE OF BIRTH CITY COUNTRY	SEX MALE ☐ FEMALE ☐
POSITION ON BOARD: MASTER ☐ DECK OFFICER ☐ ENGINEERING OFFICER ☐ RADIO OPERATOR ☐ RATING ☐		MAILING ADDRESS OF APPLICANT:	

DECLARATION OF THE AUTHORIZED PHYSICIAN			
VISION		COLOR TEST TYPE	HEARING
	WITHOUT GLASSES	WITH GLASSES	
RIGHT EYE	_____	_____	RIGHT EAR _____ LEFT EAR _____
LEFT EYE	_____	_____	
☐ BOOK ☐ LANTERN YELLOW _____ RED _____ GREEN _____ BLUE _____			
Confirmation that identification documents were checked at the point of examination: YES ☐ NO ☐			
Hearing meets the standards in STCW Code, Section A-1/9? YES ☐ NO ☐ NOT APLICABLE ☐			
Unaided hearing satisfactory? YES ☐ NO ☐			
Visual acuity meets standards in STCW Code, Section A-1/9? YES ☐ NO ☐			
Colour vision meets standards in STCW Code, Section A-1/9? YES ☐ NO ☐ (the visual test it is required every six years) Date of the last colour vision test: (Day/Month/Year) ____ / ____ / ____ .			
Are glasses or contact lenses necessary to meet the required vision standards? YES ☐ NO ☐			
Able for watchkeeping? YES ☐ NO ☐			
Is applicant taking any non-prescription or prescription medications? YES ☐ NO ☐			
Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarers unfit for such service or to endanger the health of other persons on board? YES ☐ NO ☐			

Hereby I declare that I am in knowledge of the contents of the Physical Examination.

Signature of Applicant Name of Applicant Date

CIRCLE APPROPRIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFICER / ENGINEERING OFFICER / RADIO OPERATOR / RATING) (WITHOUT ANY / WITH THE FOLLOWING) RESTRICTIONS:

NAME AND DEGREE OF PHYSICIAN: _____

ADDRESS: _____

NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: _____

DATE OF ISSUE PHYSICIAN'S CERTIFICATE: _____

SIGNATURE OF PHYSICIAN: _____	STAMP OF PHYSICIAN: _____	DATE: _____
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EXPIRY DATE OF CERTIFICATE: _____