AMERICAN CLUB PRE-EMPLOYMENT MEDICAL EXAMINATION FORM

PHOTO

IMPORTANT: The original of this form is to be kept by the clinic.

Name :			
	Last Name	**First Name**	**Middle Name**
Mailing Address :			

Date of Birth	**Blood Group**	**Place of Birth (City / Country)**	**Name of Ship**

Medical Certificate No.		**Seafarer's Certificate No.**	

Seafarer's Signature

Date:

Examination	**Results of the examination**		**Examination**	**Results of the Examination**	
	Pass	**Fail**		**Pass**	**Fail**
1. Medical History Questionnaire (attached)	☐	☐	**13. Ultrasound examination (presence of gall & kidney stones)**	☐	☐
2. Physical Examination	☐	☐	**14. Hep B Antigen**	☐	☐
3. Dental Examination	☐	☐	**15. Hep C Antibodies**	☐	☐
4. Psychological Test	☐	☐	**16. VDRL**	☐	☐
5. Visual Test	☐	☐	**17. HIV Test**	☐	☐
6. Color vision	☐	☐	**18. Stress Test**	☐	☐
7. Audiometry	☐	☐	**19. Diabetes**	☐	☐
8. Chest X-ray	☐	☐	**20. Fasting Blood Sugar**	☐	☐
9. EKG / ECG	☐	☐	**21. Glycosylated Haemoglobin (HbA1c)**	☐	☐
10. Urinalysis	☐	☐	**22. Liver Function Test (SGPT & SGOT)**	☐	☐
11. Fecalysis (food service/handlers only)	☐	☐	**23. Alcohol/Drug Test**	☐	☐
12. Complete Blood Count	☐	☐	**24 Spirometry**	☐	☐

If failed in any above mentioned examinations, please provide reasons with examination number :	

The acceptance or failure of the medical tests is based upon the ***American Club Pre-Employment Medical Examination-Acceptance Guidelines.***

Name of Medical Clinic:	
Address of Medical Clinic:	
Contact Phone:	
Contact Fax:	
Name and Degree of Physician:	
Name of Physician's Licensing:	
Date of Issue of Physician's License:	
Date of Examination:	

Signature of Physician

Official Seal

American Club Hologram

AMERICAN CLUB
MEDICAL HISTORY QUESTIONNAIRE

Hologram Sticker No. ☐

Dr.'s Initials ☐

PHOTO

Name:			**Date of Birth :**		
Address :					
		Seaman Certificate No.:		**Phone :**	
Employer :		**Vessel :**		**Job Title :**	
In Emergency, Notify :		**Relationship :**		**Ph. :**	
Personal Physician or Clinic :					
Address :					
			Physician's Phone :		

Seafarer's Signature

Date :

ALLERGIES: _____

Family History Has anyone in your family ever had :

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Heart Disease	☐	☐	Mental Illness	☐	☐
High Blood Pressure	☐	☐	Cancer	☐	☐	Epilepsy/Seizure	☐	☐

If "Yes", to any of the above, please explain:

Any other major conditions?

MALES ONLY			**If yes, give details :**	**FEMALES ONLY**		
	Yes	**No**			**Yes**	**No**
Prostate Problems	☐	☐		Pregnancy	☐	☐
Testicular Lumps	☐	☐		Breast Lumps	☐	☐
Penile Discharge	☐	☐		Menstrual Problems	☐	☐

Are you currently under a doctor's care?	☐	**Yes**	☐	**No**	
If Yes, for what problem(s)?					
Physician(s) Name/Address (if different than noted on page 1):					
History of surgeries/hospitalizations :	☐	**Yes**	☐	**No**	**Date :**
If yes, give details :					

Do you have or have received treatment for the following:

	YES	NO		YES	NO
Diabetes	☐	☐	Jaundice or Hepatitis	☐	☐
Heart Trouble	☐	☐	Dizziness	☐	☐
High Blood Pressure	☐	☐	Back Problems	☐	☐
Shortness of Breath	☐	☐	Slipped Disc	☐	☐
Chest Pain	☐	☐	Wrist Problems	☐	☐
Chronic Cough	☐	☐	Fractured Vertebrae	☐	☐
Asthma	☐	☐	Arthritis / Gout	☐	☐
Tuberculosis	☐	☐	Kidney Problems	☐	☐
Rheumatic Fever	☐	☐	Cancer / Tumor	☐	☐
Frequent Headaches	☐	☐	Rash or Skin Problem	☐	☐
Vision Problems	☐	☐	Hernia / Hydrocele	☐	☐
20/20 Vision	☐	☐	Varicose Veins	☐	☐
Epilepsy	☐	☐	Drug Problems	☐	☐
Hearing Problems	☐	☐	Mental Breakdown	☐	☐
Psychological Impairment, Depression or Mental Illness				☐	☐
Sexually Transmitted Disease				☐	☐

Date of last tetanus Vaccination:		**(dd/mm/yyyy)**
Other Vaccinations . Mention :		
Date of last dental cleaning:		**(dd/mm/yyyy)**
Date of recent dental work:		**(dd/mm/yyyy)**

	Yes	No		
Do you or did you smoke?	☐	☐	How long?	
			Packs per day?	
Do you use alcoholic beverages?	☐	☐	How much/often?	
Do you use or take any drugs?	☐	☐	Mention drugs used below :	

Are you presently on any medication :	☐	**Yes**	☐	**No**
If yes, Please list prescription and over the counter medications you take regularly:				

Would you say that your health is (please check one): ☐ **Excellent** ☐ **Good** ☐ **Fair**

DECLARATION

I, _____, Seaman's Number _____, **Hereby Declare that** I have made full disclosure of all of my medical history to the Doctors and staff of this Clinic. I am aware that the information supplied by forms the basis upon which I will be offered employment as a Seafarer. I understand that in the event of any misrepresentation either by statement or omission I will lose the right to benefit from sick pay and / or compensation which would otherwise be due under the Contract of Employment or under any Collective Bargaining Agreement. **I Also Hereby** consent to my medical records being made available upon demand to my employers and/or the Owners and/or Insurance of the Vessel or their authorized representatives.