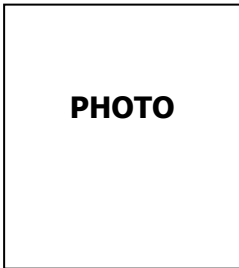




AMERICAN CLUB PRE-EMPLOYMENT MEDICAL EXAMINATION FORM



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: / /

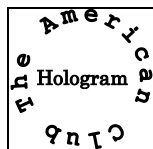
| Examination | Results of the examination | | Examination | Results of the Examination | |
|---|----------------------------|--------------------------|---|----------------------------|--------------------------|
| | Pass | Fail | | Pass | Fail |
| 1. Medical History Questionnaire (attached) | <input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





**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 | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizure | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> | | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| Testicular Lumps | <input type="checkbox"/> | <input type="checkbox"/> | | Breast Lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Penile Discharge | <input type="checkbox"/> | <input type="checkbox"/> | | Menstrual Problems | <input type="checkbox"/> | <input type="checkbox"/> |

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 :

| | | | |
|--|---|---|---------------------|
| 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) |

Do you have or have received treatment for the following:

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

| | | | |
|---------------------------------|--------------------------|--------------------------|----------------------------|
| | Yes | No | |
| Do you or did you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | How long? |
| | | | Packs per day? |
| Do you use alcoholic beverages? | <input type="checkbox"/> | <input type="checkbox"/> | How much/often? |
| Do you use or take any drugs? | <input type="checkbox"/> | <input type="checkbox"/> | 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.