Human Environment and Transport Inspectorate
Ministry of Infrastructure and Water Management

Medical examination
Shipping crew

This form is used by the medical examiner, in addition to more detailed examination, to determine if the candidate is fit for duty.

The medical examiner sends a registration of the personal data of the candidate and the outcome of the examination to the Medical Advisor of the Human Environment and Transport Inspectorate, including the reason of rejection if applicable.

The medical examiner keeps the examination data in a medical file.

The Medical Advisor has no access to the medical data without permission of the seafarer.

Contact the medical examiner for more information about this form.

More information
+31(0) 88 489 00 00 | www.ilent.nl

1 Details seafarer

1.1	Surname and Gender	☐ Male ☐ Female
1.2	First names in full	
1.3	Date of birth and place of birth	
1.4	Nationality	
1.5	Address	
1.6	Postcode and city	
1.7	Telephonenumber(s)	
1.8	Number seaman's book and country of issue	
1.9	Number of ID or passport	

2 Details of family doctor/G.P.

2.1	Name	
2.2	Address	

3 Details work/education

3.1	Name ship owner / nautical college	
3.2	Type of ship	
3.3	Duties on board the ship	
3.4	Sailing area	

4 Details of previous examinations

4.1	Have you ever been declared unfit for duty?	☐ Yes	☐ No
4.2	Have you ever been declared fit with restrictions?	☐ Yes	☐ No
4.3	Have you ever had a medical exemption?	☐ Yes	☐ No
4.4	Date of the last medical examination		
4.5	Details		

5 Details present examination

5.1	Your examination concerns	☐ Seafarer with look-out or watch duties on the bridge
		☐ Seafarer with watch duties in the engine room
		☐ Seafarer without look-out or watch duties, but with safety and/or security duties
		☐ Seafarer without safety and/or security duties

6 Medical questions

6.1	Do you experience any limitations in the performance of your duties?	☐ Yes	☐ No		
6.2	Have you ever been repatriated due to illness?	☐ Yes	☐ No		
6.3	Have you ever had an accident?	☐ Yes	☐ No		
6.4	Have you ever had surgery?	☐ Yes	☐ No		
6.5	Can you use both hands unrestricted in range of motion and sensibility?	☐ Yes	☐ No		
6.6	Have you suffered from any occupational disease?	☐ Yes	☐ No		
6.7	Are you allergic to any substance?	☐ Yes	☐ No		
6.8	Are you night blind?	☐ Yes	☐ No		
6.9	Do you wear glasses or contact lenses?	☐ Yes	☐ No		
6.10	Is your colour vision normal?	☐ Yes	☐ No		
6.11	Have you had eye surgery or laser treatment?	☐ Yes	☐ No		
6.12	Do you use a hearing-aid?	☐ Yes	☐ No		
6.13	Do you take any medication? If so, which?	☐ Yes	☐ No		
6.14	Do you drink alcohol? If so, how many units per week?	☐ Yes	☐ No		a week
6.15	Do you smoke? If so, how many per day?	☐ Yes	☐ No		a day
6.16	Did you use illegal drugs during the past 5 years?	☐ Yes	☐ No		
6.17	Are you pregnant? Expected date of delivery?	☐ Yes	☐ No	☐ N.a.	
6.18	Do you have painful or irregular periods?	☐ yes	☐ No	☐ N.a.	
6.19	When was your last visit to the dentist?				
6.20	Can you turn a rescue raft? (STCW-training)				
6.21	Are you able to wear a breathing apparatus? (STCW-training)				

6.22 Details

7 Physical complaints

7.1 Do or did you suffer from any of the following?

Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Thyroid disorders	☐ Yes	☐ No
Contagious diseases, tropical diseases	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Trombosis or embolism	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Epilepsy, seizures or convulsions	☐ Yes	☐ No
Psychological problems	☐ Yes	☐ No
Alcohol dependency	☐ Yes	☐ No
Nervous strain, depression	☐ Yes	☐ No
Fear of heights / open spaces / claustrophobia	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Sleep-walking, bed-wetting	☐ Yes	☐ No
Skin diseases, eczema	☐ Yes	☐ No
Venereal diseases	☐ Yes	☐ No
Inguinal hernia	☐ Yes	☐ No
Varicose veins, haemorrhoids	☐ Yes	☐ No
Headache, dizziness	☐ Yes	☐ No
Syncope, fainting	☐ Yes	☐ No
Low vision or blurred vision	☐ Yes	☐ No
Poor hearing or ringing in the ear	☐ Yes	☐ No

Coughing, shortness of breath	☐ Yes	☐ No
Asthma, bronchitis	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Heart diseases	☐ Yes	☐ No
Chest pain, palpitations	☐ Yes	☐ No
Swollen feet, especially in the evening	☐ Yes	☐ No
Stomach-ache, nausea, low appetite	☐ Yes	☐ No
Abdominal pain, cramps	☐ Yes	☐ No
Black or discoloured stools	☐ Yes	☐ No
Strain or pain during urinating	☐ Yes	☐ No
Pain in the back	☐ Yes	☐ No
Painful arms, legs or joints	☐ Yes	☐ No
Fractures, dislocations	☐ Yes	☐ No
Seasickness	☐ Yes	☐ No

7.2 Details

8 Signature

The undersigned is aware of the fact that due to false or inaccurate completion of this medical history the medical examination may be considered invalid. The undersigned therefore certifies that the personal declaration above is a true statement to the best of his or her knowledge.

8.1 Place and date

8.2 Signature