MARINE MEDICAL EXAMINATION REPORT Form **1095**

PART A (TO BE COMPLETED BY APPLICANT)

1.Surname:	Middle Name:	First Name:
2.Address:		Nationality:
3. Place of Birth: (Country)	4. Date of Birth:	5. Male: ____ Female: ___
6. Is this your first marine medical report? Yes ___ (go to Part B) No ___ (Skip Part B	7. Have you had a marine accident since your last marine medical examination? No ____ Yes ____ Date of accident: _____Vessel Involved: (dd/mm/yyyy)	
8. Have you ever been refused issue or renewal of a Master's certificate? ____ Yes ____ No	9. Last marine medical examination date:	

PART B (TO BE COMPLETED BY APPLICANT)

REVIEW OF SYSTEMS

Have you ever had or been treated for any of the following?

	Yes	**No**		**Yes**	**No**
1. Head injury, dizziness, loss of consciousness			7. Cardiovascular disorder including hypertension		
2. Frequent or severe headaches			8. Musculo – Skeletal disorder		
3. Epilepsy			9. Alcohol or substance abuse Weekly alcohol intake (_____Oz.).		
4. Psychiatric/Neurological problems			10. Sight Impairment		
5. Ear disease or deafness			11. Pulmonary Disorder including Asthma		
6. Allergies			12. Current medication		

Details of any medical conditions referred to above:

List injuries, operations, serious illness and dates:

STATEMENT OF APPLICANT

I hereby declare that I have read and understand the above information which to the best of my knowledge is complete and correct. I recognize that this report and any other medical documentation submitted by me as a part of my application for a certification is the property of the Belize ports Authority.
I authorize the release of any information contained herein or in other relevant general medical examination reports including electrocardiograms, X-ray reports, and eye specialist reports to the authorities and release this and other relevant medical information to the Belize Ports Authority. Advisors for the sole purpose of establishing my medical fitness to hold any license or permit issued by The Belize Ports Authority. I am aware that this is an offence under the Laws of Belize to knowingly make a false declaration.

_____	_____	_____
Date (dd/mm/yyyy)	Applicant's Signature	Witness

PART C

PHYSICAL EXAMINATION BY LICENSED PHYSICIAN

1.Height Ft. In.	2. Weight Lbs.	3. Colour of eyes		4. Blood Pressure (Syst.) / (Dias.)

Check each item	Normal	Abnormal		11. Elaborate on each abnormal response with diagnosis if possible
5. Nose and Throat				
6. Ears				
7. Respiratory System				
8. Cardiovascular System				
9. Locomotor skills				
10. Neurological condition				

VISUAL EXAMINATION

1. Acuity		Distant	Near	Contact Lenses	Glasses
	Left eye				
	Right eye				

		Normal	Abnormal
	Optic Functionality		
	Visual Fields		

2. Lens Prescription	(No @ 30-50cm	Uncorrected		Corrected	
		Yes	No	Yes	No
	Right Eye				
	Left Eye				

3. Do you recommend an eye examination by a specialist?
No _____ (complete examination)

Yes _____ (If yes, applicant must provide assessment of specialist along with the medical form)

COLOUR PERCEPTION EXAMINATION

1. Pseudoisochromatic PLATES	Type		Number of plates	Number of errors
2. Lantern (if applicable)	☐ Pass		☐ Fail	

HEARING EXAMINATION

1. Whisper voice at (6ft) ☐ Pass ☐ Fail
2. Conversational Voice at (9ft) ☐ Pass ☐ Fail

3. Recommendations:

Other tests recommended/ comments etc.

PART D – (TO BE COMPLETED BY PHYSICIAN)

Physician's Assessment for Master's License: ☐ Fit ☐ Unfit ☐ Fit with limitations described below:
Limitations if any:

_____ _____ _____

Name in print of examining Physician | Signature | Date (dd/mm/yyyy)

Stamp of Physician