



Serial No. of Medical Certificate/Declaration of unfitness:

E. SELF-DECLARATION

Have you, or have you ever had any of the following conditions?

No	Condition	Yes:	No:
1.	Eye/vision problems	<input type="checkbox"/>	<input type="checkbox"/>
2.	Undergone a refractive eye surgery? If yes, reply 2a, 2b and 2c	<input type="checkbox"/>	<input type="checkbox"/>
2a	Night vision problems compared to prior to the surgery	<input type="checkbox"/>	<input type="checkbox"/>
2b	Complications after the surgery	<input type="checkbox"/>	<input type="checkbox"/>
2c	Need for a new refractive eye surgery	<input type="checkbox"/>	<input type="checkbox"/>
3.	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
4.	Heart/vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
5.	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
6.	Varicose veins/piles	<input type="checkbox"/>	<input type="checkbox"/>
7.	Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
8.	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
9.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
10.	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
11.	Digestion disorder	<input type="checkbox"/>	<input type="checkbox"/>
12.	Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>
13.	Skin problem	<input type="checkbox"/>	<input type="checkbox"/>
14.	Allergies (hayfever, allergic eczema or other allergic conditions)	<input type="checkbox"/>	<input type="checkbox"/>
15.	Infectious/contagious disease	<input type="checkbox"/>	<input type="checkbox"/>
16.	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
17.	Genital disorder	<input type="checkbox"/>	<input type="checkbox"/>
18.	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
19.	Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>
20.	Operation/surgery	<input type="checkbox"/>	<input type="checkbox"/>
21.	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
22.	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
23.	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
24.	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
25.	Depression	<input type="checkbox"/>	<input type="checkbox"/>
26.	Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
27.	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
28.	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>
29.	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
30.	Ear (hearing, tinnitus)/nose/throat problem	<input type="checkbox"/>	<input type="checkbox"/>
31.	Restricted mobility	<input type="checkbox"/>	<input type="checkbox"/>
32.	Back or joint problem	<input type="checkbox"/>	<input type="checkbox"/>
33.	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
34.	Fractures/dislocations	<input type="checkbox"/>	<input type="checkbox"/>
35.	Smoke or have smoked tobacco	<input type="checkbox"/>	<input type="checkbox"/>
36.	Use/abuse of alcohol	<input type="checkbox"/>	<input type="checkbox"/>
37.	Use/abuse of drugs	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the above questions, please give details:

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No	Additional questions	Yes:	No:
38.	Have you ever been signed off or sent home due to illness?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Have you ever been declared unfit to work on board ship?	<input type="checkbox"/>	<input type="checkbox"/>
41.	Have your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
42.	Are you aware that you have any medical problems, diseases or illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
43.	Do you feel healthy and fit to perform the duties of your designated position/occupation?	<input type="checkbox"/>	<input type="checkbox"/>
Supplementary information:			
No	The Appellate Body	Yes:	No:
44.	Have you ever appealed the seafarer's doctor's decision or applied for exemption from the health requirements?	<input type="checkbox"/>	<input type="checkbox"/>
45.	If you replied "Yes" to the above question, have you informed the seafarer's doctor that you are seeing now of the Appellate Body's decision in the case?	<input type="checkbox"/>	<input type="checkbox"/>
No	Medication	Yes:	No:
46.	Have you ever reacted allergically on medications you have been given?	<input type="checkbox"/>	<input type="checkbox"/>
47.	Are you taking any non-prescription or prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", please list the medications taken, and the purpose(s) and dosage(s):			

I hereby declare that the information above is complete and correct. I am aware that I will not be entitled to salary from the company if I have fraudulently concealed an injury or illness at the time of appointment, or if I have deliberately contracted the injury or illness after the appointment, cf. section 4-4 third paragraph of the Act of 21 June 2013 No. 102 relating to employment protection etc. for employees on board ships (Ship Labour Act). The concealment of injury or illness will be considered fraudulent if the injury or illness is related to health requirements to be satisfied pursuant to section 17 of the Act of 16 February 2007 No. 9 relating to Ship Safety and Security (Ship Safety and Security Act).

I am aware that I shall consult a seafarer's doctor without unjustified delay for a medical examination if I have reason to believe that I no longer satisfies the health requirements, and that I must inform the master or the shipping company of this, cf. section 6 third paragraph of the Health Regulations.

Place:	Date:	Employee's signature:
Certified by:	The witness' signature, and witness' name in typed letters:	

F. CONSENT TO COLLECT MEDICAL INFORMATION

I hereby agree that relevant medical information relating to my previous illnesses may be obtained from a National Insurance office, doctor, hospital, other health institution and/or public authority by the approved seafarer's doctor, _____, for use in connection with the seafarer's doctor's assessment and, if applicable, for use by the Appellate Body pursuant to the Health Regulations.

Place:	Date:	Employee's signature:
Certified by:	The witness' signature, and witness' name in typed letters:	