|  |  |
| --- | --- |
| ki) | *KIRIBATI SHIP REGISTRY* |
|  Certificate for Medical Fitness Examination |

*\* Select as appropriate.*

|  |
| --- |
| **Applicant’s Particulars** |
| *Name in Full (Block Capitals)* | *Passport No:* |
|  |  |
| *Date of Birth:* | *Place of Birth:* | *Nationality:* | *Sex \*:* | *Rank:* |
|  |  |  | *[ ] Male /* *[ ] Female* |  |
| *Address:* | *Tel no:*  |  |
|  | *Email Address:*  |  |

#### Doctor’s Examination Report

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *1* | *Height/Weight* |  | *Metres* |  | *Kilos* |
| *2* | *Hearing* |  | *Right* |  | *Left* |
| *3* | *Eyesight* |  | *Right* |  | *Left* |  | *Color Vision* |
| *4* | *Urinanalysis* |  | *Sugar* |  | *Albumin* |  | *Microscopy* |
| *5* | *Full blood count* |  | *Hb* |  | *WBC* |  | *Platelets* |
| *6* | *VDRL* |  | *Negative* |  | *Positive* |
| *7* | *Chest X-Ray Report**(last X Ray within a year)* |  | *Normal* |  | *Abnormal* |
| *8* | *Electrocardiogram**(ECG) (EDG)* |  | *Normal* |  | *Abnormal* |
| *9* | *Pulse* |  | *Per min* |
| *10* | *Blood Pressure* |  |
|  |  |  |
|  |  |  | *Normal* | *Abnormal* | *If abnormal gives details* |
| *11* | *Cardiovascular system* | [ ]  | [ ]  |  |
| *12* | *Central Nervous system* | [ ]  | [ ]  |  |
| *13* | *Digestive System* | [ ]  | [ ]  |  |
| *14* | *Locomotor system (spine/limbs)* | [ ]  | [ ]  |  |
| *15* | *Skin (including varicosities)* | [ ]  | [ ]  |  |
| *16* | *Physique –Deformities* | [ ]  | [ ]  |  |
| *17* | *Respiratory system* | [ ]  | [ ]  |  |
| *18* | *Intelligence, mental state* | [ ]  | [ ]  |  |
| *19* | *Gastrointestinal system (eg Hernia)* | [ ]  | [ ]  |  |
| *20* | *Urogenital system (eg Hydrocoele)* | [ ]  | [ ]  |  |
| *21* | *Endocrine system (eg Thyroid)* | [ ]  | [ ]  |  |
| *22* | *Eyes* | [ ]  | [ ]  |  |
| *23* | *Ears/ Nose/Throat* | [ ]  | [ ]  |  |
| *24* | *Mouth/Teeth* | [ ]  | [ ]  |  |

**Doctor’s Remarks & Declaration**

|  |
| --- |
| Certificate of Medical Fitness |
| *I certify that I have examined Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, NRIC / PP No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to the medical standards of the Kiribati Ship Registry and found (him / her)\* deemed to be (FIT / UNFIT)\*.**Remarks (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *Official Stamp Date of Examination Date of Expiry\*\* Signature & Name of Doctor Name of Medical Institute/Hospital*\*\*Normally 2 years from Date of Examination unless the Attending Doctor requires otherwise. |