|  |  |
| --- | --- |
| 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. |