

Seafarers' Medical Examination Form

Applicant full name:

First	Last
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Date of birth:

MM/DD/YYYY

Email address:

Examination for duty as:

<input type="radio"/> Master	<input type="radio"/> Deck officer	<input type="radio"/> Engineering officer
<input type="radio"/> Radio officer	<input type="radio"/> Rating	<input type="radio"/> Others

Height & Weight:

Do you wear glasses or contact lenses?

Yes No

Do you take any non-prescription or prescription medication?

(If yes, please detail)