

**Seafarers Self
Declaration Form
Uberrima fides**



Family Name:	Given Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (day/month/year):	Crew Position:
Seaman's Book No:	Crew I.D. No:	ID Confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Passport No:	Nationality:

DO YOU HAVE, DID YOU EVER HAVE OR HAVE YOU BEEN TOLD YOU HAVE: (to be completed by crew member)

IF YOU ANSWER "Yes" TO ANY OF THE QUESTIONS IN THIS SECTION, PLEASE PROVIDE AN EXPLANATION ON THE NEXT PAGE.

If you do not understand any terms you must ask your medical provider to explain.

CONDITION	Yes	No
1. Do you feel healthy and fit to perform the duties of your designated position/occupation? If "No" specify below: Explanation:	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you signed off as sick or repatriated from a ship?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you aware that you have any medical problems, diseases or illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you drink alcohol? How much per day _____ week _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you smoke? How many years? How much per day?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been Hospitalised ? For What? When?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had ANY type of surgery? For What? When?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever received a blood transfusion? Why?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you taking ANY medications?	<input type="checkbox"/>	<input type="checkbox"/>
12. Alternative Medicine or Treatment? What?	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC		
13. Attempted Suicide?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had thoughts of Harming Self or Others?	<input type="checkbox"/>	<input type="checkbox"/>
15. Psychiatric Problems/Bipolar/Other Disorders?	<input type="checkbox"/>	<input type="checkbox"/>
16. Nervous Breakdown/Depression/Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
17. Attention deficit/hyperactivity disorder (ADHD)?	<input type="checkbox"/>	<input type="checkbox"/>
18. Difficulty Concentrating on Things?	<input type="checkbox"/>	<input type="checkbox"/>
19. Trouble Falling Asleep, Staying Asleep or Sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>
ORTHOPEDIC		
20. Neck Pain/Scoliosis/Cervical Injury/Radiating Pain?	<input type="checkbox"/>	<input type="checkbox"/>
21. Back Pain/Injury/Sciatica/Radiating Pain?	<input type="checkbox"/>	<input type="checkbox"/>
22. Hand/Wrist Pain or Numbness?	<input type="checkbox"/>	<input type="checkbox"/>
23. Elbow Pain/Injury/Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
24. Shoulder Pain/Injury/Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
25. Knee Pain/Injury/Surgery/Osteoarthritis?	<input type="checkbox"/>	<input type="checkbox"/>
26. Feet Pain/Numbness/Tingling/Injury/Surgery/Heel Pain?	<input type="checkbox"/>	<input type="checkbox"/>
27. Sprains/Dislocations/Fractures?	<input type="checkbox"/>	<input type="checkbox"/>
INFECTIOUS DISEASES		
28. Rheumatic Fever (autoimmune)?	<input type="checkbox"/>	<input type="checkbox"/>
29. Infectious/Contagious Diseases?	<input type="checkbox"/>	<input type="checkbox"/>
30. Syphilis/HIV/Gonorrhoea/Other Sexually Transmitted Disease?	<input type="checkbox"/>	<input type="checkbox"/>
31. Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
32. Tuberculosis (TB)? Date ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
33. Yellow Fever/Scarlet Fever/Malaria/Tropical Diseases?	<input type="checkbox"/>	<input type="checkbox"/>
34. Viral/Mononucleosis/Chicken Pox/Measles/Mumps?	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	Yes	No
CARDIAC		
35. Chest Pain? Palpitations?	<input type="checkbox"/>	<input type="checkbox"/>
36. Heart Attack/Irregular Heart Beat/Rate?	<input type="checkbox"/>	<input type="checkbox"/>
37. Heart Disease?	<input type="checkbox"/>	<input type="checkbox"/>
38. Heart Surgery/Pacemaker/ICD Implantable (cardiac defibrillator)?	<input type="checkbox"/>	<input type="checkbox"/>
39. High Blood Pressure? Date of Diagnosis: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINOLOGY		
40. Diabetes? <input type="checkbox"/> Type Unknown <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/>	<input type="checkbox"/>
41. Thyroid (weight loss, sweats, tremors) or Other Endocrine Disorders?	<input type="checkbox"/>	<input type="checkbox"/>
GASTROENTEROLOGY		
42. Gastritis/Reflux/Gastric or Duodenal Ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
43. Frequent Diarrhoea or Constipation/Straining/Pain?	<input type="checkbox"/>	<input type="checkbox"/>
44. Bleeding from Stomach or Bowels?	<input type="checkbox"/>	<input type="checkbox"/>
45. Haemorrhoids/Rectal Bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
46. Jaundice (Yellow Eyes/Skin)/Gallbladder/Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
47. Hernias of Any Kind/Hernia Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
48. Abdominal Pain?	<input type="checkbox"/>	<input type="checkbox"/>
PULMONARY		
49. Asthma or Wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
50. Bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
51. Pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
52. Coughing Up Blood?	<input type="checkbox"/>	<input type="checkbox"/>
53. Pulmonary Embolism?	<input type="checkbox"/>	<input type="checkbox"/>
54. Shortness of Breath?	<input type="checkbox"/>	<input type="checkbox"/>
55. Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGY		
56. Headaches/Dizziness/Loss of Consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
57. Head Injury or Concussion?	<input type="checkbox"/>	<input type="checkbox"/>
58. Fainting?	<input type="checkbox"/>	<input type="checkbox"/>
59. Seizures/Epilepsy/Receiving Medications for Either?	<input type="checkbox"/>	<input type="checkbox"/>
60. Loss of Memory?	<input type="checkbox"/>	<input type="checkbox"/>
61. Stroke/Mini-Stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
62. Muscular Weakness?	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD DISORDERS		
63. Anaemia/Sickle Cell Anaemia?	<input type="checkbox"/>	<input type="checkbox"/>
64. Hemophilia?	<input type="checkbox"/>	<input type="checkbox"/>
65. Leukaemia?	<input type="checkbox"/>	<input type="checkbox"/>
66. Other Blood Disorders?	<input type="checkbox"/>	<input type="checkbox"/>
UROLOGY		
67. Kidney Problems/Dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
68. Bladder Infection/Blood in Urine/Kidney Stones?	<input type="checkbox"/>	<input type="checkbox"/>
69. Prostate Disease (Males)?	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION

By signing the below, I hereby certify that the information contained in this form is true, correct, and complete to the best of my knowledge and belief. I understand that any false information, misrepresentation, or omission of facts in this form are grounds for loss of benefits (including without limitation, medical benefits, sick pay, maintenance, death benefits, and disability benefits), disqualification from further consideration, and/or immediate termination of employment without recourse.

SIGNATURE OF EXAMINEE:

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DATE:

.....

WITNESS NAME:

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WITNESS SIGNATURE:

.....

DATE:

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AUTHORISATION FOR USE AND DISCLOSURE OF INFORMATION

I understand the purpose of this examination is for West of England in accordance with West of England’s PEME program:

- To obtain information that may be used to determine fitness for duty and/or
- To comply with legal or other reporting obligations, and/or
- To investigate any pre-existing disease.
- To assert or defend against legal claims.

To achieve the above purposes, I hereby request and authorise The Marine Advisory Medical Service to release all relevant medical records and information from any source, including hospitals, clinics, labs, physicians, psychologists, employers, insurance companies, government authorities, and any other health professionals, health institutions, or public authorities (collectively, ‘Medical Records’) to any Marine Advisory Medical Service medical personnel, any third party performing medical record review, and any other person or entity necessary for The Marine Advisory Medical Service to determine or verify whether I am fit for duty in accordance with the enhanced criteria.

In the event I make a claim for medical benefits, sick pay, death, or disability benefits, or any other benefit, I further authorise The Marine Advisory Medical Service to release any relevant Medical Records to West of England, the ship owner or manning agency personnel to make a claim determination or resolve a claim dispute or appeal. I authorise the release of all my Medical Records to the physician(s) performing the medical examination subject of this form.

I hereby authorise the release of my medical records, including patient history, office notes, test results, radiology studies, films, referrals, consultants and billing records, even if said record(s) include information related to alcohol, drug abuse, mental health treatment, or confidential HIV related information, to all parties aforementioned.

Further, I acknowledge that my Medical Data might be transferred to countries inside or outside the European Union (EU) and/or the European Economic Area (EEA). When we transfer your Medical Data outside the EU/EEA, the laws and rules that protect your Medical Data in such countries may be different (or less protective) from your own country.

Your consent declaration is completely voluntary, and you may, as well, revoke it at any time. The withholding or revocation of your consent will not have any negative, especially no disciplinary, consequences. However, your employer or manning agency might not be able to assign you to certain tasks that require an approved level of fitness if you withhold or withdraw your consent. If you revoke your consent, this will not impact the legitimacy of the previous use of your data that was based on your initial declaration of consent. The Marine Advisory Medical Service is the controller of the said data. You may revoke your consent by email to admin@marinemed.co.uk. If there is another legal basis for processing, The Marine Advisory Medical Service reserves the right to process the data on such other legal basis. You may also request access the data which we hold, which will be made available to you on request.

My signature below signifies that, to the best of my knowledge and belief, all information, answers and responses provided to the company, or company designated physicians, laboratory or medical staff, are true and correct. I fully understand that if I falsify or withhold relevant medical information or condition(s) and/or fail to provide West of England or its medical advisors, with updated information as necessary subsequent to the date of this document, such action or inaction may serve as grounds for termination of my employment without employment benefits. I also authorise release of any/all medical information concerning my past, present or future medical condition(s), by any medical practitioner or provider, to West of England and its medical advisors or its authorised representative. I am able to read, write and speak English and fully understand all of the above information.

SIGNATURE OF EXAMINEE:
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DATE:
.....

WITNESS NAME:
.....

WITNESS SIGNATURE:
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DATE:
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ACKNOWLEDGEMENT BY PHYSICIAN

I acknowledge that I have reviewed the information contained in this form with the Applicant and noted Comments as required.

PHYSICIAN SIGNATURE:

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PHYSICIAN NAME (please print):

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PHYSICIAN PHONE NUMBER:

.....

DATE:

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