



Merchant Shipping Directorate



## MEDICAL FITNESS CERTIFICATE

### *Merchant Shipping Notice 107*

*Notice to Shipowners, Ship Operators, Managers, Masters,  
Owners' Representatives and Recognised Organisations*

The Merchant Shipping Directorate would like to draw the attention of all concerned to the new medical certificate for seafarers issued in accordance with the IMO/ILO Guidelines on the medical examination of seafarers. The new medical form meets the standards enshrined in the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (STCW), as amended, the Maritime Labour Convention (MLC), 2006, the provisions of the Merchant Shipping Act, the Merchant Shipping (Training and Certification) Regulations and the Merchant Shipping (Maritime Labour Convention) Rules.

Part A of the medical form is to be completed by the applicant and signed in the presence of a duly qualified medical practitioner who is to complete part B, including the medical certificate for service at sea.

Medical certificates issued prior to 1 October 2013 shall remain valid until their expiry date.

A copy of the medical certificate may be downloaded from:  
[www.transport.gov.mt/admin/uploads/media-library/files/Notice%20107%20-%20New%20Medical%20Form.doc](http://www.transport.gov.mt/admin/uploads/media-library/files/Notice%20107%20-%20New%20Medical%20Form.doc)

Merchant Shipping Directorate

19 September 2013

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[www.transport.gov.mt/ship-registration](http://www.transport.gov.mt/ship-registration)

Transport Malta is the Authority for Transport in Malta set up by Act XV of 2009

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<b>PART A – To be completed by applicant</b>					
<i>Surname (Family Name)</i>	<i>First Name</i>		<i>Second Name</i>		
<i>Date of Birth</i>	<i>Country of Birth</i>		<i>Nationality</i>		
<i>Department</i>					
Deck <input type="checkbox"/> Engine <input type="checkbox"/> Radio <input type="checkbox"/> Other <input type="checkbox"/> Please specify:					
<i>Passport No. / Discharge Book No. / Identity Card No.</i>				<i>Gender</i>	
				Male <input type="checkbox"/> Female <input type="checkbox"/>	
<i>Address</i>					
<b>Applicant's personal declaration (Assistance should be offered by medical staff)</b>					
• Have you ever had any of the following conditions:					
Condition	Yes	No	Condition	Yes	No
1. Eye / vision problem	<input type="checkbox"/>	<input type="checkbox"/>	18. Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you smoke, use alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart / vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	20. Operation / surgery	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	21. Epilepsy / seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Varicose veins / piles	<input type="checkbox"/>	<input type="checkbox"/>	22. Dizziness / fainting	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma / bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	23. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
7. Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	24. Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	25. Depression	<input type="checkbox"/>	<input type="checkbox"/>
9. Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	26. Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
10. Digestive disorder	<input type="checkbox"/>	<input type="checkbox"/>	27. Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
11. Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	28. Balance problem	<input type="checkbox"/>	<input type="checkbox"/>
12. Skin problem	<input type="checkbox"/>	<input type="checkbox"/>	29. Severe headache	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	30. Ear (hearing/tinnitus)/nose/ throat problem	<input type="checkbox"/>	<input type="checkbox"/>
14. Infectious / contagious diseases	<input type="checkbox"/>	<input type="checkbox"/>	31. Restricted mobility	<input type="checkbox"/>	<input type="checkbox"/>
15. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	32. Back or joint problem	<input type="checkbox"/>	<input type="checkbox"/>
16. Genital disorder	<input type="checkbox"/>	<input type="checkbox"/>	33. Amputation	<input type="checkbox"/>	<input type="checkbox"/>
17. Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	34. Fractures / dislocations	<input type="checkbox"/>	<input type="checkbox"/>
If you answered <b>yes</b> to any of the above questions, please write details below:					
• Additional questions:					
35. Have you ever been signed off as sick or repatriated from a ship?				Yes	No
36. Have you ever been hospitalized?				<input type="checkbox"/>	<input type="checkbox"/>
37. Have you ever been declared unfit for sea duty?				<input type="checkbox"/>	<input type="checkbox"/>
38. Has your medical certificate ever been restricted or revoked?				<input type="checkbox"/>	<input type="checkbox"/>
39. Are you aware that you have any medical problems, diseases or illnesses?				<input type="checkbox"/>	<input type="checkbox"/>
40. Do you feel healthy and fit to perform the duties of your designated position / occupation?				<input type="checkbox"/>	<input type="checkbox"/>
41. Are you allergic to any medication?				<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

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	Yes	No
42. Are you taking any non-prescription or prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>yes</b> , please list the medications taken, and the purpose/s and dosage/s:		
<b>Applicant must sign personal declaration in the presence of a duly qualified medical practitioner who will be filling PART B of this medical report</b>		
I hereby certify that the personal declaration above is a true statement to the best of my knowledge. Furthermore, I authorize the release of all my records from any health professionals, health institutions and public authorities to the appointed medical practitioner.		
Applicant's Signature (Signed in the presence of medical practitioner)		Date:

PART B – To be completed by a duly qualified medical practitioner										
<b>Medical Examination</b>										
Height	(cm)		Weight	(kg)		Pulse Rate	/ (minute)		Rhythm	
Blood pressure (mm HG)					Urinalysis					
Systolic		Diastolic		Glucose		Protein		Blood		
<b>Sight (Table on the "Minimum in-service eyesight standards for seafarers" is found on page 4 of this medical report)</b>										
Use of glasses or contact lenses: Yes <input type="checkbox"/> No <input type="checkbox"/>										
<i>Visual acuity</i>						<i>Visual fields</i>				
Unaided			Aided							
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular		Right eye	Left eye	
Distant							Normal			
Near							Defective			
Colour vision	Not tested	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Doubtful	<input type="checkbox"/>	Defective	<input type="checkbox"/>		
<b>Hearing</b>										
<i>Pure tone and audiometry (threshold values in dB)</i>						<i>Speech and whisper test (metres)</i>				
	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz		Normal	Whisper	
Right ear							Right ear			
Left ear							Left ear			
		Normal	Abnormal					Normal	Abnormal	
1. Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Sinuses, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Mouth / teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Vascular (inc. pedal pulses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ears (general)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Abdomen and viscera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Tympanic membrane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Anus (not rectal exam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Ophthalmoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. G-U system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Pupils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Upper and lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Eye movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Spine (C/S, T/S and L/S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Lungs and chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Neurologic (full brief)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Breast examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. General appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>Chest X-ray</b>	<input type="checkbox"/> Not performed	<input type="checkbox"/> Performed on
Results:		
<b>Other diagnostic test/s and results:</b>		
Test:	Result:	
Medical practitioner's comments and assessment for fitness, with reasons for any limitations:		
Vaccination status recorded:    Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>Medical certificate for service at sea</b>		
Surname (Family Name)	First Name	Second Name
Date of Birth	Country of Birth	Nationality
Department Deck <input type="checkbox"/> Engine <input type="checkbox"/> Radio <input type="checkbox"/> Other <input type="checkbox"/> Please specify:		
Passport No. / Discharge Book No. / Identity Card No.		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>Declaration of duly qualified medical practitioner</b>		
	Yes	No
Confirmation that applicant's identification documents were checked?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing meets the standards in STCW Code, section A-I/9?	<input type="checkbox"/>	<input type="checkbox"/>
Visual acuity meets standards in STCW Code, section A-I9?	<input type="checkbox"/>	<input type="checkbox"/>
Colour vision meets standards in STCW Code, section A-I9?	<input type="checkbox"/>	<input type="checkbox"/>
Fit for lookout duties?	<input type="checkbox"/>	<input type="checkbox"/>
Is applicant suffering from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on boards?	<input type="checkbox"/>	<input type="checkbox"/>
<b>This is to certify that I have examined the applicant and that my findings are recorded in this medical report</b>		
Result:		
Fit for Sea Duty <input type="checkbox"/>	Unfit for Sea Duty <input type="checkbox"/>	**Fit with limitations or restrictions <input type="checkbox"/>
**Please specify limitations or restrictions, if any:		
Signature of duly qualified medical practitioner	Applicant's Signature (Signed in the presence of medical practitioner)	
Medical practitioner's stamp	Date of Examination	
<b>Validity</b>		
Date of Issue:		
<i>This medical certificate shall remain valid for a maximum period of two years unless the seafarer is under the age of 18, in which case the maximum period of validity shall be one year.</i>		

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*Table A-I/9*  
**Minimum in-service eyesight standards for seafarers**

STCW Convention regulation	Category of seafarer	Distance vision Aided <sup>1</sup>		Near/immediate vision Both eyes together, aided or unaided	Colour vision <sup>3</sup>	Visual fields <sup>4</sup>	Night blindness <sup>4</sup>	Diplopia (double vision) <sup>4</sup>
		One eye	Other eye					
I/11 II/1 II/2 II/3 II/4 II/5 VII/2	Masters, deck officers and ratings required to undertake look-out duties	0.5 <sup>2</sup>	0.5	Vision required for ship's navigation (e.g., chart and nautical publication reference, use of bridge instrumentation and equipment, and identification of aids to navigation)	See Note 6	Normal Visual fields	Vision required to perform all necessary functions in darkness without compromise	No significant condition evident
I/11 III/1 III/2 III/3 III/4 III/5 III/6 III/7 VII/2	All engineer officers, electro-technical officers, electro-technical ratings and ratings or others forming part of an engine-room watch	0.4 <sup>5</sup>	0.4 (see Note 5)	Vision required to read instruments in close proximity, to operate equipment, and to identify systems/ components as necessary	See Note 7	Sufficient visual fields	Vision required to perform all necessary functions in darkness without compromise	No significant condition evident
I/11 IV/2	GMDSS Radio operators	0.4	0.4	Vision required to read instruments in close proximity, to operate equipment, and to identify systems/ components as necessary	See Note 7	Sufficient visual fields	Vision required to perform all necessary functions in darkness without compromise	No significant condition evident

Notes:

- <sup>1</sup> Values given in Snellen decimal notation.
- <sup>2</sup> A value of at least 0.7 in one eye is recommended to reduce the risk of undetected underlying eye disease.
- <sup>3</sup> As defined in the *International Recommendations for Colour Vision Requirements for Transport* by the Commission Internationale de l'Eclairage (CIE-143-2001 including any subsequent versions).
- <sup>4</sup> Subject to assessment by a clinical vision specialist where indicated by initial examination findings.
- <sup>5</sup> Engine department personnel shall have a combined eyesight vision of at least 0.4.
- <sup>6</sup> CIE colour vision standard 1 or 2.
- <sup>7</sup> CIE colour vision standard 1, 2 or 3.