



AMERICAN CLUB PRE-EMPLOYMENT MEDICAL EXAMINATION FORM—2017

IMPORTANT: The original of this form is to be kept by the seafarer. A copy must be kept by the clinic.

Date of Examination: _____/_____/_____ (dd/mm/yyyy)

PHOTOGRAPH

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Name:			
	Last Name	First Name	Middle Name
Mailing Address:			
Date of Birth (dd/mm/yyyy)	Blood Type/Group	Place of Birth (City/Country)	Name of Ship/Vessel
Medical Certificate No.:		Seafarer's Certificate No.:	

Seafarer's Signature

NOTE: The passing or failure of the medical examinations for the following is based upon the 2017 *American Club Pre-Employment Medical Examination Guidelines*. All relevant examinations must be completed and recorded below.

Examination	Results of Examination		Examination	Results of Examination	
	Pass	Fail		Pass	Fail
1. Medical History Questionnaire (attached)	<input type="checkbox"/>	<input type="checkbox"/>	13. Ultrasound examination (presence of gall and/or kidney stones)	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	14. Hep B Antigen	<input type="checkbox"/>	<input type="checkbox"/>
3. Dental Examination	<input type="checkbox"/>	<input type="checkbox"/>	15. Hep C Antibodies	<input type="checkbox"/>	<input type="checkbox"/>
4. Psychological Test	<input type="checkbox"/>	<input type="checkbox"/>	16. VDRL	<input type="checkbox"/>	<input type="checkbox"/>
5. Visual Test	<input type="checkbox"/>	<input type="checkbox"/>	17. HIV Test	<input type="checkbox"/>	<input type="checkbox"/>
6. Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	18. Stress Test	<input type="checkbox"/>	<input type="checkbox"/>
7. Audiometry	<input type="checkbox"/>	<input type="checkbox"/>	19. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
8. Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	20. Fasting Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
9. Electro Cardiogram (ECG or EKG)	<input type="checkbox"/>	<input type="checkbox"/>	21. Glycosylated Haemoglobin (HbA1c)	<input type="checkbox"/>	<input type="checkbox"/>
10. Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	22. Liver Function Test	<input type="checkbox"/>	<input type="checkbox"/>
11. Fecalalysis (food service/handlers only)	<input type="checkbox"/>	<input type="checkbox"/>	23. Alcohol/Drug Test	<input type="checkbox"/>	<input type="checkbox"/>
12. Complete Blood Count	<input type="checkbox"/>	<input type="checkbox"/>	24. Spirometry	<input type="checkbox"/>	<input type="checkbox"/>

If failed in any of the abovementioned examinations, please provide an explanation for the failure with the associated examination number:	
Exam # _____	
Exam # _____	
Exam # _____	

Has medication been prescribed because of this PEME?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	If "YES", the American Club PEME Declaration Form MUST BE completed (third page).
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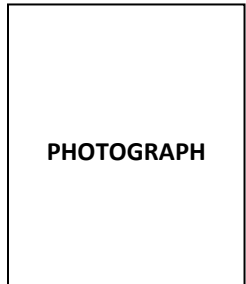
Name of Medical Clinic:		<div style="border: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> <div style="text-align: center;"> <p>Signature of Physician</p> <div style="border: 1px solid black; width: 80%; height: 40px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 60%; height: 60px; margin: 10px auto; display: flex; align-items: center; justify-content: center;"> <p>American Club Hologram to be placed here</p> </div> </div> </div>
Address of Medical Clinic:		
Contact Phone No.:		
Contact Fax No.:		
Name and Degree of Physician:		
Name of Physician's Licensing Body:		
Date of Issue of Physician's License:		
Date of Completed PEME Examination:		
Expiry Date for PEME: <i>(cannot be less than one calendar year)</i>		



AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2017

IMPORTANT: This medical history form must be completed in the presence of the clinic physician.

American Club Hologram Sticker No. (from previous page): _____
 Doctor's Initials: _____



Seafarer's Signature

Name:	Last Name		First Name		Middle Name
	Home Address:				
Date of Birth (dd/mm/yyyy)	Phone No.	Seaman's Certificate No.		Employer	
In case of emergency, notify:			Relationship:		
Address:			Phone No.:		

Personal Physician or Clinic:	Physician's Phone No.:	
Address:		

Family History					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" to any of the above, please explain: _____

Any other major medical or physical conditions? _____

MALE ONLY	YES	NO	FEMALE ONLY	YES	NO
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Testicular Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Penile Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" to any of the above, please explain: _____

	YES	NO
Are you currently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
If "YES", for what problem(s)?		
Physician's name and address (if different from the one noted above)		
Have you had surgeries or have been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
If "YES", provide the date(s) and give details below:		

Date of last Tetanus vaccination:	(dd/mm/yyyy)
List other vaccinations/dates:	(dd/mm/yyyy)
Date of last dental cleaning:	(dd/mm/yyyy)
Date of any recent dental work:	(dd/mm/yyyy)

Overall, would you say that your health is (please check only one):

Excellent Good Fair

Have you received treatment for the following?					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Slipped Disk	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Fractured Vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rash or Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hernia/Hydrocele	<input type="checkbox"/>	<input type="checkbox"/>
20/20 Vision	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Mental Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Impairment, Depression or Mental Illness				<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease				<input type="checkbox"/>	<input type="checkbox"/>

Allergies	YES	NO
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>

If you have allergies, please describe: _____

	YES	NO	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If "YES", how long?
			If "YES", how many packs per day?
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If "YES", how much and how often:
Do you use or take any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If "YES", name the drugs and how often used:

Are you presently on any medication(s)?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
If "YES", please list prescription and over the counter medications you take regularly:				

DECLARATION

I, _____, Seaman's Number _____, **Hereby Declare** that I have made full disclosure of all of my medical history to the Doctors and staff of this Clinic. I am aware that the information supplied by forms the basis upon which I will be offered employment as a Seafarer. I understand that in the event of any misrepresentation either by statement or omission I will lose the right to benefit from sick pay and / or compensation which would otherwise be due under the Contract of Employment or under any Collective Bargaining Agreement. **I Also Hereby** consent to my medical records being made available upon demand to my employers and/or the Owners and/or Insurance of the Vessel or their authorized representatives.



AMERICAN CLUB DECLARATION FORM —2017

IMPORTANT: If medication has been prescribed by the clinic, the seafarers BMI has been found to be between 30 and 32.9, or any other relevant medical condition requiring lifestyle changes has been found, as a condition of issuing this American Club PEME certificate, this form MUST BE completed by the clinic.

American Club Hologram Sticker No. (from first page): _____

Doctor's Initials: _____

I, _____, Seaman's Number _____, **Hereby Declare** that I understand that I have been issued an American Club pre-employment medical examination form according to the standards of American P&I club so that I may be employed on the understanding that I will be responsible for taking the following prescribed medication(s) (*name(s) of prescribed medication(s)*):

.....
.....

In addition, the following medical recommendation have been given to me by the doctor for the medical condition of (*name(s) of prescribed medication(s)*)

.....
.....

(*name of doctor(s), name of clinic, this physician is required to sign this form at the bottom*)

.....
has explained to me what my condition is, what medication is required and how this should be administered.

I hereby agree to ensure that I follow taking prescribed medication and following medical recommendation given to me by the doctor and that I will take responsibility for making arrangements to secure the medication during the course of my employment as prescribed. Any additional medical evaluations and testing I may need because of the pre-existing condition are to my responsibility.

My signature below acknowledges my receipt and understanding of this Declaration and I that I had an opportunity to discuss any questions or concerns about this notice with a member of the PEME team and that my noncompliance with this undertaking have been fully explained to me and I confirm that I understand the same.

I have given the original of this Declaration to the medical facility where the American Club pre-employment medical examination form has been issued. I confirm to keep the copy of this Declaration through the term of validity of pre-employment medical examination form.

Seafarer's Signature: _____

Date: _____ (mm/dd/yyyy)

Witnessed by:
(Physician's signature): _____