

FEDERAL REPUBLIC OF NIGERIA



006028

FEDERAL MARITIME ADMINISTRATION AND SAFETY AGENCY  
SEAFARERS' MEDICAL CERTIFICATE

This Certificate is issued by the Government of Federal Republic of Nigeria  
Under Regulation 1.2 Standard A1.2 of Maritime Labour Convention, 2006

Surname: KANU Other Names: EMEKA

Date of Birth: 7/05/1983 Discharge Book No: \_\_\_\_\_

Sex  M  F Department: Deck  Engine  Radio  Catering  Others \_\_\_\_\_

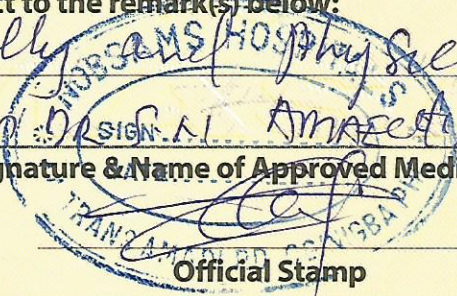
Date of Medical Examination: 11/12/2015 Date of expiry of this certificate: 10/12/2017

I certify that I have examined the seafarer named above and have found him/her  
FIT/NOT FIT for seafaring duties subject to the remark(s) below:

Remark(s) He is mentally healthy

HRM. DR. SIGN. N. Amaze JP

Signature & Name of Approved Medical Officer



Official Stamp

© NSFMPLC 2014

ORIGINAL



**FEDERAL REPUBLIC OF NIGERIA**  
**NIGERIAN MARITIME ADMINISTRATION AND SAFETY AGENCY**  
**SEAFARERS' MEDICAL CERTIFICATION APPLICATION FORM**  
 UNDER REGULATION 1.2, STANDARD A1.2, OF MLC 2006

**A. APPLICANT'S BIODATA**

SURNAME: KANU OTHER NAMES: EMEKA  
 DATE OF BIRTH: 7/5/83 AGE: \_\_\_\_\_ SEX: M NATIONALITY: NIGERIAN  
 DATE OF APPLICATION: 11/12/2015 PLACE OF BIRTH: \_\_\_\_\_  
 Discharge Book NO.: NIG-028869 Company BOURBON Vessel \_\_\_\_\_  
 Address: NO 3B ELIJAH AVENUE WOI  
 DEPT OF SHIP: DECK:  ENGINE:  CATERING:  MASTER/MATE:  OTHERS SPECIFY: \_\_\_\_\_

**B. APPLICANT'S MEDICAL HISTORY (Under guidance from a medical personnel)**

Have you ever had

- |  | YES                      | NO                                  |   | YES                      | NO                                  |
|--|--------------------------|-------------------------------------|---|--------------------------|-------------------------------------|
| (1) Admission to hospital whatever reason at all in the past     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (16) Sexually Transmitted diseases (Gonorrhoea, Syphilis, AIDS etc) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (2) Any surgical operation                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (17) Any persistent Muscular weakness                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (3) Any accident   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (18) Loss of consciousness  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (4) Any mental illness   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (19) Pain in spine, Back or any Joint                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (5) Any convulsions  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (20) Balance problem  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (6) Any Ear or Hearing problem                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (21) Anal pain or swelling  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (7) Any persistent Cough   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (22) Restricted mobility  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (8) Difficulty with breathing or breathlessness on mild exertion | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (23) Excessive thirst   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (9) Palpitations   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (24) A sign-off as sick or a repatriation from a ship ?             | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (10) High blood pressure   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (25) Excessive weight loss  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (11) Chest pain at rest or on exertion                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (26) An unfit declaration for sea duty ?                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (12) Stomach pain  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (27) Sugar in the Urine   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (13) Any vomiting  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (28) Your medical certificate restricted or revoked ?               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (14) Blood in vomitus or stool                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (29) To wear contact Lens or Glasses                                | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (15) Any problem passing urine                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | (30) To be placed on any medication                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**2. IMMUNIZATION HISTORY (Have you been immunized before)**

- |   |   |  |  |
|---|---|--|--|
| (A) Tetanus <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES DATE _____      | (B) Typhoid Fever <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES DATE _____ | (C) Cholera <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES DATE _____      | (D) Meningitis <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES DATE _____ |
| (E) Yellow Fever <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES DATE _____ | (F) Hepatitis <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES DATE _____     | (G) Tuberculosis <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES DATE _____ |  |

**3. SOCIAL/FAMILY HISTORY**

- (A) Do you smoke, Take Alcohol or use drugs ?  YES  NO
- (B) Has any member of your family or relative had mental illness, Epilepsy, Blood disorder, Heart trouble, Hypertension or any other disorder (eg. Allergy etc.)  YES  NO
- (C) You have a medical or other condition not  YES  NO

I KANU EMEKA declare that the information given above is correct to the best of my knowledge. I consent to the examining doctor to endorse my medical information on the Medical fitness Certificate for official purposes (To be signed only in the presence of examining doctor)

11/12/2015  
Date

KANU EMEKA  
Name of Applicant



# NIGERIAN MARITIME ADMINISTRATION AND SAFETY AGENCY

## SEAFARERS' MEDICAL EXAMINATION

### PHYSICIAN'S EXAMINATION REPORT FOR SEAFARERS UNDER REGULATION 1.2, STANDARD A1.2, OF MLC 2006

Name: KANU EMEKA (Surname first) Discharge Book No. \_\_\_\_\_

#### APPEARANCE

*He is mentally and physically fit for work*

#### GENERAL EXAMINATION

Weight: 75kg Height: 1.78m Normal  Abnormal   
 Gait    
 Temperature: 36.6/m Blood Pressure: 120/80mmHg Pulse Rate: \_\_\_\_\_ Pallor: \_\_\_\_\_  
 Palpable  Impalpable  If palpable, state region/location  
 Lymph Nodes

#### SYSTEMIC EXAMINATION

	Normal	Abnormal
(1) Central Nervous System	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(2) Cardiovascular System	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(3) Respiratory System	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(4) Gastrointestinal System	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(5) Hernial Orifices	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(6) Endocrine System	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(7) Locomotor System	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(8) Orodental	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(9) Skin (including Varicosities)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(10) Ear, Nose & Throat.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

#### OTHER EXAMINATIONS

	Normal	Abnormal
(1) Speech (Voice Communication)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(2) Hearing	RT <input type="checkbox"/>	LT <input type="checkbox"/>
	- Audiometry <input type="checkbox"/>	<input type="checkbox"/>

#### (3) Eyesight

Visual Acuity	RT	LT
Without glasses	<u>6/6</u>	<u>6/6</u>
With glasses	<u>6/6</u>	<u>6/6</u>
Colour vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(1) Blood group & Genotype \_\_\_\_\_ & \_\_\_\_\_  
 (2) Full blood count \_\_\_\_\_  
 (3) VDRL  Negative  Positive  
 (4) HIV  Negative  Positive  
 (5) Hepatitis B Antigen  Negative  Positive  
 (6) Widal (for Catering Dept.) \_\_\_\_\_  
 (7) Urinalysis \_\_\_\_\_  
 (8) Chest X-Ray with Report  Normal  Abnormal  
 (9) Electrocardiogram  Normal  Abnormal

HRM DR. S.N. AMAECHI  
Physician's Name

NOBBAMS HOSPITAL  
NO 44 TRANS AMADI  
080 330 91363

