

FEDERAL REPUBLIC OF NIGERIA



000265

0103

NIGERIAN MARITIME ADMINISTRATION AND SAFETY AGENCY SEAFARERS MEDICAL CERTIFICATE

Surname: ORUKPE Others Names: STANLEY

Date of Birth: 10-05-1982 Discharge Book No:

Department: Deck Engine Radio Catering Others

Date of Medical Examination: 20/4/15 Date of expiry of this certificate: 20/4/15

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) MEDICALLY FIT

J. J. Lily Hospital, Princeside
Signature & Name of Approved Medical Officer

SAFETY COPY

Official Stamp
WARRI

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Official Stamp
WARRI

1
2
3

4
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FEDERAL REPUBLIC OF NIGERIA
NIGERIAN MARITIME ADMINISTRATION AND SAFETY AGENCY
SEAFARERS' MEDICAL CERTIFICATION APPLICATION FORM

A. APPLICANT'S BIODATA

SURNAME: ORUKE

OTHER NAMES: STANLEY

DATE OF BIRTH: 10/05/82 SEX: M

NATIONALITY: NIGERIA

DATE OF APPLICATION: 20/04/2015

PLACE OF BIRTH: EDO STATE

Discharge Book No: _____

Address: George O. Crescent Ekae 1 off Sapele road Blcity Edo^{State}

DEPT OF SHIP: DECK ENGINE CATERING OTHERS SPECIFY _____
 MASTER / MATE

B. APPLICANTS MEDICAL HISTORY (Under guidance from a medical personnel)

Have you Ever Had	YES	NO	If Yes Provide Details
(1) Admission to hospital whatever reason at all in the past	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>OPERATION</u>
(2) Any surgical Operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>APPENDIX</u>
(3) Any Accident	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(4) Any Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(5) Any Convulsions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(6) Any Ear or Hearing Problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(7) Any Persistent Cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(8) Difficulty With Breathing or Breathlessness on mild exertion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(9) Palpitations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(10) High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(11) Chest Pain at Rest or on Exertion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(12) Stomach Pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(13) Any Vomiting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(14) Blood in Vomitus or Stool	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(15) Any Problem Passing Urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
(16) Sexually Transmitted Diseases (Gonorrhoea, Syphilis, AIDS etc)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____

- (17) Any Persistent Muscular Weakness
- (18) Loss of consciousness
- (19) Pain in Spine, Back or any Joint
- (20) Balance problem
- (21) Anal Pain or Swelling
- (22) Restricted mobility
- (23) Excessive Thirst
- (24) A sign-off as sick or a repatriation from a ship?
- (25) Excessive Weight Loss
- (26) An unfit declaration for sea duty?
- (27) Sugar in the Urine
- (28) Your medical certificate restricted or revoked?
- (29) To wear contact Lens or Glasses
- (30) To be placed on any Medication

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

- | | | | |
|-------------------|--------------------------|--------------------------|--------------------|
| (A) Tetanus | <input type="checkbox"/> | <input type="checkbox"/> | If yes Date |
| (B) Typhoid Fever | <input type="checkbox"/> | <input type="checkbox"/> | |
| (C) Cholera | <input type="checkbox"/> | <input type="checkbox"/> | |
| (D) Meningitis | <input type="checkbox"/> | <input type="checkbox"/> | |
| (E) Yellow Fever | <input type="checkbox"/> | <input type="checkbox"/> | |
| (F) Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | |
| (G) Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | |

3. **SOCIAL/FAMILY HISTORY**

- | | | | |
|--|--------------------------|--------------------------|-------------------------------|
| (A) Do you smoke, Take Alcohol or Use Drugs | <input type="checkbox"/> | <input type="checkbox"/> | If yes Provide Details |
| (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.) | <input type="checkbox"/> | <input type="checkbox"/> | |
| (C) You have a medical or other condition not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> | |
| (D) Others | | | |

I, ORUKPE STANLEY, 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 the examining doctor)

20/04/2015
Date

ORUKPE STANLEY
Name of Applicant


Signature of Applicant



LILY HOSPITAL LIMITED, WARRISON



No 6 Brisbane lane, off Etuwewe Road, off Deco Road, Warri

FORM 2: PRE-EMPLOYMENT/PRE-PLACEMENT MEDICAL TEST REPORT

COMPANY	PRIVATE				DATE	20/1/2015	
SURNAME	ORUKEPE		OTHER NAMES	STANLEY			
AGE	32 YRS	SEX	MALE	OCCUPATION	DRILLING		

PHYSICAL EXAMINATION PRELIMINARIES

Height (m)	1.74	Pulse rate (B/M)	76	BP Recheck	
Weight (kg)	72	BP: Systolic (mmHg)	110	/	
Body mass index	23.62	Bp: Diastolic (mmHg)	80		

SYSTEM REVIEW

	Normal	Abnormal	Remark
Eye, Ear, Nose, Throat	✓		
Head and Neck	✓		
Breast/ Chest	✓		
Respiratory system	✓		
Cardiovascular system	✓		
Gastro-intestinal system	✓		
Musculoskeletal system	✓		
CNS & Peripheral nervous system	✓		
Uro-genital system	✓		
Skin	✓		

LABORATORY INVESTIGATIONS

SEROLOGY		HAEMATOLOGIST		
Test	Result	Test	Result	
VDRL/TPHA	Negative	PCV (%)	43	
HIV	Negative @ 20/1/15	HB (mg/dl)	13.3	
Hepatitis A		WBC (mm ³)	5700	RBC
Hepatitis B	Negative	ESR (mm/hr)		
Hepatitis C		Widal test	Insignificant	
Blood group	A positive	Mantoux test (mm)	5	
Genotype		BIOCHEMISTRY		
Drug panel		Test	Result	Range
Alcohol		RBS/ FBS (mg/dl)		80-140
Pregnancy test		Cholesterol (mg/dl)		115-200
		Triglycerides (mg/dl)		70-150
		HDL-cholesterol(mg/dl)		40-75
		LDL-cholesterol (mg/dl)		60-150
MICROBIOLOGY		Urea (mg/dl)		15-39
Urine micro		Creatinine (mg/dl)		0.5-1.1
Urine M/C/S		Sodium (meq/l)		135-155
Stool occult blood		Potassium(meq/l)		3.5-5.5
Stool R/E		Chloride(meq/l)		96-106
Stool M/C/S		Bicarbonate(meq/l)		18-28
Sputum AFB X 3		Urinalysis	Normal	

Others (please specify)

OTHER INVESTIGATIONS

VISUAL TEST

TEST	Normal	Abnormal
Chest X-ray		✓
ECG		✓
Treadmill ECG		
Whispering test		
Audiometry	✓	
Spirometry		
Peak flow		
Sleep apnea		
Exercise step test		

Eye test	Uncorrected	Corrected
Visual acuity	Right: 6/6	Right: 6/
	Left: 6/12	Left: 6/
Near vision	Right: N. 8	Right: N.
	Left: N. 8	Left: N.
Color vision	Normal	Abnormal
	✓	
Visual field	Normal	Abnormal

VACCINE CHART

Vaccines	Tetanus Toxoid	Hepatitis A	Hepatitis B	Yellow Fever	Typhoid
Given					

SUMMARY OF EVALUATION

Significant history	Significant physical findings	Significant investigation findings									
DETAILS IN QUESTIONNAIRE	N.G.	<table border="1"> <tr> <td>Visual acuity</td> <td>Right: 6/6</td> <td>Left: 6/12</td> </tr> <tr> <td>Color vision</td> <td>Normal</td> <td>Abnormal</td> </tr> <tr> <td>Visual field</td> <td>Normal</td> <td>Abnormal</td> </tr> </table>	Visual acuity	Right: 6/6	Left: 6/12	Color vision	Normal	Abnormal	Visual field	Normal	Abnormal
		Visual acuity	Right: 6/6	Left: 6/12							
Color vision	Normal	Abnormal									
Visual field	Normal	Abnormal									

VACCINE CHART

Vaccines	Tetanus Toxoid	Hepatitis A	Hepatitis B	Yellow Fever	Typhoid
Medically		At			

LILY HOSPITAL LTD.

Occupational Health Practitioner's Signature: _____ Date 29/4/2015

Hospital stamp:

WARRI



ID: 0000000000000001

10-May-1982 Male

Orakpo Stanley

Normal sinus rhythm ✓
Voltage criteria for left ventricular hypertrophy ✓
Early repolarization ✓
Abnormal ECG

*Abnormal ECG.
Schroter*

Vent. rate 64 bpm
QRS duration 86 ms
QT/QTc 386/398 ms
PR interval 142 ms
P duration 86 ms
RR interval 937 ms
P-R-T axes 75 24 30

MAC600 1.02

12SL™ v239

MAC600 1.02

12SL™ v239

GE

MAC600 1.02

ID: 0000000000000001

20-Apr-2015 11:43:18

aVR

V1

V4

aVL

V2

V5

II

aVF

V6

0.16-150Hz 25.0 mm/s 10.0 mm/mV

64 bpm

4 by 2.5s

III





LILY HOSPITALS LIMITED, WARRI

No 6 Brisbane lane, off Etuwewe Road, Off Deco Road, Warri

AUDIOMETRY QUESTIONNAIRE



Please, answer all questions. If you are not sure of any question, ask your health advisor what it means.

PERSONAL DETAILS

COMPANY	Private	DATE	20/04/2015
SURNAME	Orukpe Stanley	ID No.	
OTHER NAME	NIL	CURRENT WORK LOCATION	Liberia Lagos
AGE	33 ⁺	SEX	M
GSM NO.:	08067500932	JOB TITLE	
		DEPARTMENT	Drilling Crew

Employment History - starting with the most recent one

Employer	Location	Job title	Duration (yrs)	Noise level (L/M/H)	Hearing Protection worn?
Estymol oil & gas	Lagos	Drilling Crew	4 yrs		yes
DES process	PH	Maritime	2 yrs		yes
EAS G	Benin	field Engineer	2 yrs		yes
Guinness mg plc	Benin	Utility Dept	1 1/2 yrs		yes

Army Service

Location	Type	Duration (yrs)	Noise level (L/M/H)	Hearing Protection worn?

Gun fire	Hearing Protection worn?	Yes	No
Explosion	Hearing Protection worn?	Yes	No

GENERAL HEALTH HISTORY

Have you had any of the following?	Yes	No	If yes, give details
High blood pressure		<input checked="" type="checkbox"/>	
Diabetes mellitus		<input checked="" type="checkbox"/>	
Kidney disease		<input checked="" type="checkbox"/>	
Cancer		<input checked="" type="checkbox"/>	
Head injury /spinal injury		<input checked="" type="checkbox"/>	
<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Meningitis <input type="checkbox"/> chicken pox		<input checked="" type="checkbox"/>	
<input type="checkbox"/> Scarlet fever <input type="checkbox"/> Rheumatic fever		<input checked="" type="checkbox"/>	
High fever		<input checked="" type="checkbox"/>	
Allergies		<input checked="" type="checkbox"/>	
Recent sinus problem		<input checked="" type="checkbox"/>	
Dizziness, vertigo, problem with balance		<input checked="" type="checkbox"/>	
Tinnitus or ringing in the ear		<input checked="" type="checkbox"/>	
Hearing loss or deafness		<input checked="" type="checkbox"/>	
Use of hearing aid		<input checked="" type="checkbox"/>	
Ear or mastoid operation		<input checked="" type="checkbox"/>	
Ear infection / Drainage from ears		<input checked="" type="checkbox"/>	
Injury / trauma to ear or perforation of ear drum		<input checked="" type="checkbox"/>	

Yes No If yes, give details

Do you engage or have engaged in any of the following?	Yes	No	If yes, give details
Motorcycles	<input checked="" type="checkbox"/>		work
Power tools(chain saw, snow/leaf blower, metal grinding, lawnmower)	<input checked="" type="checkbox"/>		work
Loud music		<input checked="" type="checkbox"/>	
Gun fire (hunting, shooting)/ blast/explosion			
Power boating		<input checked="" type="checkbox"/>	
Diving / boxing		<input checked="" type="checkbox"/>	
Home tractor / farm machinery	<input checked="" type="checkbox"/>		yard & home
Woodwork /Carpentry		<input checked="" type="checkbox"/>	
Race cars / work on running engines	<input checked="" type="checkbox"/>		work
Private flying	<input checked="" type="checkbox"/>		work
Other loud noise	<input checked="" type="checkbox"/>		work
Any family history of hearing loss before 50yrs?		<input checked="" type="checkbox"/>	
Do have any condition that prevents you from wearing hearing protectors?		<input checked="" type="checkbox"/>	
Do you use hearing protection outside work?		<input checked="" type="checkbox"/>	
Do you use hearing protection at work?	<input checked="" type="checkbox"/>		work
Are you exposed to loud hand tools at work?	<input checked="" type="checkbox"/>		work
Has your noise exposure at increased in the last year?	<input checked="" type="checkbox"/>		work
Have you been exposed to noise in the last 14 hours?	Yes	No	If yes, give details
As a child, were you exposed to noise in the neighborhood e.g from milling engines?		<input checked="" type="checkbox"/>	

Clients comments/ explanation:

NH

For office use only

Visual examination

External appearance normal Left: Yes / No Right: Yes / No

OTOSCOPIC EXAMINATION

Is wax blocking the ear drum (< 50% of ear drum visible?) Left: Yes / No Right: Yes / No

Is there discharge in the ear canal? Left: Yes / No Right: Yes / No

The left ear drum is Normal Scarred perforated

The right ear drum is Normal Scarred perforated

Examiner's comments:

Satisfactory on both ears

Examiner's name: Joke-Isaac

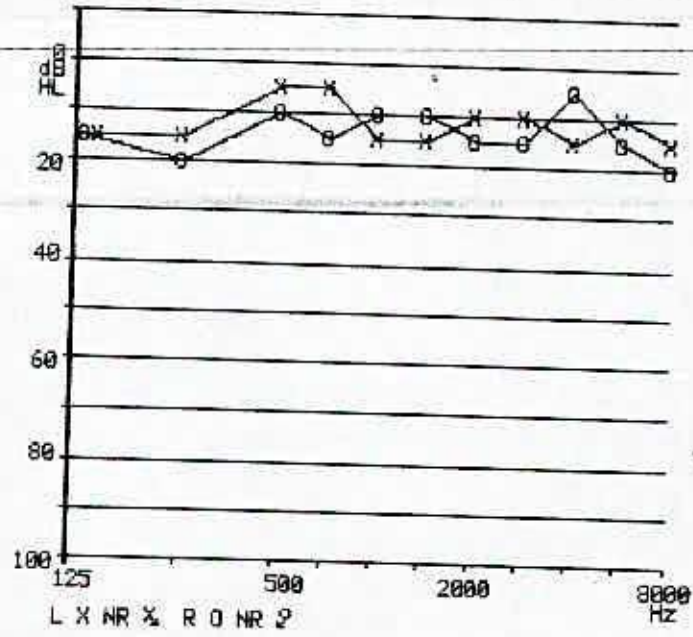
Signature:

Date: 20/1/15

Left: Yes / No Right: Yes / No

Private

NAME Onufre Stanley ^{BSI 38}
DATE 2014/15







Patient Name :Mr. ORUKPE STANLEY
 Age :32 Y
 Sex :Male
 Doctor :DR IMHONTU OTAIGBE
 Lab ID No: :
 Status :Final

MR No :MR057455
 Sample collection date :20-04-2015 09:27
 Test Date :20-04-2015 10:26
 Report Date :20-04-2015 10:27
 Ward/Bed :/

SEAFARERS MEDICALS

Biochemistry/Clinical Chemistry

Test Description	Result	Biological Reference Range	Units
Urinalysis			
Specimen:Urine			
COLOUR	AMBER		
APPEARANCE	CLEAR		
PH	5.0		
SPECIFIC GRAVITY	1.020		
GLUCOSE	NEGATIVE		
PROTEIN	NEGATIVE		
KETONES	NEGATIVE		
BLOOD	NEGATIVE		
UROBILINOGEN	NEGATIVE		
BILIRUBIN	NEGATIVE		
NITRITE	NEGATIVE		
LEUCOCYTES	NEGATIVE		
ASCORBIC ACID	NEGATIVE		

— End Of The Report —

Lewis

Technician





Patient Name :Mr. ORUKPE STANLEY
Age :32 Y
Sex :Male
Doctor :DR IMHONTU OTAIGBE
Lab ID No: :
Status :Provisional

MR No :MR057455
Sample collection date :20-04-2015 09:27
Test Date :20-04-2015 11:42
Report Date :20-04-2015 16:19
Ward/Bed :/

SEAFARERS MEDICALS

Haematology

Test Description	Result	Biological Reference Range	Units
Blood Group Specimen:Blood			
BG	A RH 'D' POSITIVE		
Full Blood Count Specimen:Blood			
WBC	5700	4000 - 11000 / MM ³	MM3
HB	13.3	12 - 18 g / dl	g/dl
PCV	40	36 - 54 %	%
NEUTROPHIL	43	45 - 70 %	%
LYMPHOCYTES	48	25 - 40 %	%
MONOCYTES	MID=9	5 - 15 %	%
RBC	4.9	4.0 - 6.0 MIL / cm ³	mil/cm ³
PLATELET	180000		

Serology

Test Description	Result	Biological Reference Range	Units
VDRL Specimen:Blood	NEGATIVE		

Microbiology

Test Description	Result	Biological Reference Range	Units
Hiv Rapid Specimen:Blood			
HIV R	NEGATIVE		
Hepatitis B-Rapid Specimen:Blood			





HBSAG

NEGATIVE

Serology

Test Description	Result	Biological Reference Range	Units
WIDAL			
Specimen: Blood			
SALMONELLA TYPHI O	< 1:20	< 1:20	
SALMONELLA PARATYPHI A	< 1:20	< 1:20	
SALMONELLA PARATYPHI B	< 1:20	< 1:20	
SALMONELLA PARATYPHI C	< 1:20	< 1:20	
SALMONELLA PARATYPHI H	< 1:20	< 1:20	
SALMONELLA PARATYPHI A.	< 1:20	< 1:20	
SALMONELLA PARATYPHI B.	< 1:20	< 1:20	
SALMONELLA PARATYPHI C.	< 1:20	< 1:20	

NEGATIVE

— End Of The Report —

Lewis	Result	Biological Reference Range	Units Technician
	< 1:20	< 1:20	
	< 1:20	< 1:20	
	< 1:20	< 1:20	
	< 1:20	< 1:20	
	< 1:20	< 1:20	
	< 1:20	< 1:20	
	< 1:20	< 1:20	





Patient Name :Mr. ORUKPE STANLEY
Age :32 Y
Sex :Male
Doctor :DR IMHONTU OTAIGBE
Lab ID No: :
Status :Final

MR No :MR057455
Sample collection date :20-04-2015 09:27
Test Date :20-04-2015 14:07
Report Date :20-04-2015 14:07
Ward/Bed :/

SEAFARERS MEDICALS

Haematology

Test Description	Result	Biological Reference Range	Units
Genotype Specimen:Blood			
GT	AS		

----- End Of The Report -----

Lewis

Technician

