



When completed this form shall be retained onboard and used only to facilitate proper medical treatment for the seafarer. The original of this form should accompany the seafarer for treatment ashore and be returned to the vessel after treatment.

**1 Vessel and Location Details**

Vessel Name: \_\_\_\_\_ IMO Number: \_\_\_\_\_  
Vessel Owner: \_\_\_\_\_ Flag of Vessel: \_\_\_\_\_  
Location (Lat / Long or Port) at the onset of illness or injury: \_\_\_\_\_  
Next Port: \_\_\_\_\_ ETA (Date): \_\_\_\_\_

**2 The Seafarer (Patient)**

Full Name: \_\_\_\_\_ Sex: Male  Female   
Date of Birth: \_\_\_\_\_ Nationality: \_\_\_\_\_  
Identity Document Number: \_\_\_\_\_ Passport  Discharge Book  Other   
Position/Rank: \_\_\_\_\_  
Date and Time off work: \_\_\_\_\_ Returned to work: \_\_\_\_\_

**3 The Injury or Illness**

Date and time of injury or onset of illness: \_\_\_\_\_  
Date and time of first examination onboard: \_\_\_\_\_  
Symptoms: \_\_\_\_\_ Findings of onboard examination: \_\_\_\_\_  
Treatment administered onboard: \_\_\_\_\_ Condition of patient after treatment: \_\_\_\_\_  
Medical Advice Obtained: Yes  No  Shore Treatment Recommended: Yes  No   
MEDIVAC Arranged: Yes  No  Date and time MEDIVAC undertaken: \_\_\_\_\_

Master's Full Name: \_\_\_\_\_  
Date: \_\_\_\_\_

\_\_\_\_\_  
Master's Signature

**4 Remote Medical Assistance (If Required)**

Name of Medical Advisor: \_\_\_\_\_ TMAS Centre: \_\_\_\_\_  
Date and time of first contact with medical advisor: \_\_\_\_\_  
Medical Advice Received: \_\_\_\_\_



**5 For use by the examining Doctor**

After examination of the patient, please complete this form and return to the vessel's master (or local agent). Please enclose all relevant medical reports when returning this form.

Diagnosis:

Treatment or Medication Administered:

Further Treatment or Medication Required:

Further Doctors Visit Required: Yes  No

Suggested Date for Next Examination:

Estimated duration of illness or incapacity (Days):

**6 To be completed if Patient is FIT FOR WORK**

Fit for work now  Fit for work from  , Date:

Fit for work with restrictions

Details of any restrictions on work:

**7 To be completed if Patient is UNFIT FOR WORK**

Unfit for work now  Estimated Duration (Days):

Bed Rest Required  Estimated Duration (Days):

The patient should leave the vessel  and be:

Admitted to Hospital

Repatriated

Patient May Travel by Air

Unaccompanied

Only With Medical Escort

Medical Treatment Required at Final Destination:

**8 Declaration by Doctor**

Date of this Medical Examination:

Charge for Examination:

Payment Received: Yes  No

Full Name, Address and Telephone of Doctor:

Empty box for Doctor's Signature

Doctor's Signature

Empty box for Doctors' Stamp

Doctors' Stamp