KIRIBATI SHIP REGISTRY

Certificate for Medical Fitness Examination

**** Select as appropriate.***

Applicant's Particulars				
Name in Full (Block Capitals)				*Passport No:*
Date of Birth:	*Place of Birth:*	*Nationality:*	*Sex *:*	*Rank:*
			☐*Male* / ☐*Female*	
Address:			*Tel no:*	
			Email Address:	

Doctor's Examination Report

1	*Height/Weight*		*Metres*		*Kilos*		
2	*Hearing*		*Right*		*Left*		
3	*Eyesight*		*Right*		*Left*		*Color Vision*
4	*Urinanalysis*		*Sugar*		*Albumin*		*Microscopy*
5	*Full blood count*		*Hb*		*WBC*		*Platelets*
6	*VDRL*		*Negative*		*Positive*		
7	*Chest X-Ray Report (last X Ray within a year)*		*Normal*		*Abnormal*		
8	*Electrocardiogram (ECG) (EDG)*		*Normal*		*Abnormal*		
9	*Pulse*		*Per min*				
10	*Blood Pressure*						

		Normal	*Abnormal*	*If abnormal gives details*
11	*Cardiovascular system*	☐	☐	
12	*Central Nervous system*	☐	☐	
13	*Digestive System*	☐	☐	
14	*Locomotor system (spine/limbs)*	☐	☐	
15	*Skin (including varicosities)*	☐	☐	
16	*Physique –Deformities*	☐	☐	
17	*Respiratory system*	☐	☐	
18	*Intelligence, mental state*	☐	☐	
19	*Gastrointestinal system (eg Hernia)*	☐	☐	
20	*Urogenital system (eg Hydrocoele)*	☐	☐	
21	*Endocrine system (eg Thyroid)*	☐	☐	
22	*Eyes*	☐	☐	
23	*Ears/ Nose/Throat*	☐	☐	
24	*Mouth/Teeth*	☐	☐	

Doctor's Remarks & Declaration

Certificate of Medical Fitness

I certify that I have examined Mr. _____, *NRIC / PP No* _____ *to the medical standards of the Kiribati Ship Registry and found (him / her)* deemed to be (FIT / UNFIT)*.*

Remarks (if any) _____

_____	_____	_____	_____	_____
Official Stamp	*Date of Examination*	*Date of Expiry***	*Signature & Name of Doctor*	*Name of Medical Institute/Hospital*

**Normally 2 years from Date of Examination unless the Attending Doctor requires otherwise.