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CIRCULAR NO. 24/08

TO MEMBERS OF THE ASSOCIATION

Dear Member:

PRE-EMPLOYMENT MEDICAL EXAMINATION PROGRAM (PEME): AMENDMENT TO CLUB PEME FORMS TO INCLUDE MEDICAL HISTORY QUESTIONNAIRE

The American Club is introducing an amendment to the pre-employment medical examination (PEME) program policy to further ensure that Members are made aware of pre-existing medical conditions affecting seafarers prior to employment.

With effect from February 20, 2009, the American Club will require the attached medical history questionnaire to be completed by the seafarer as part of the Club-approved medical form. The new questionnaire will be integrated into the Club approved medical forms that can be found on the American Club website under Loss Prevention at www.american-club.com.

The new policy will apply to Members employing seafarers originating from India, Indonesia, Latvia, Philippines, Poland, Romania, Russia, and Ukraine.

The primary purpose of the medical history questionnaire is to:

(a) protect the interests of Members by reason of seafarers being compelled to provide a full account of their medical history at the time of the PEME; and

(b) prevent against spurious illness claims through a signed declaration of their knowledge of any prior or current condition that may not necessarily be detected during the PEME, but at some later date.

For further information, please refer to the American Club website at www.american-club.com or contact Dr. William Moore, Senior Vice President of Risk Control for the Shipowners Claims Bureau, Inc. at Tel: +1 212 847 4542, Fax: +1 212 847 4596 or william.moore@american-club.com.

Yours faithfully,

Joseph E. M. Hughes, Chairman & CEO
Shipowners Claims Bureau, Inc., Managers for
THE AMERICAN CLUB

ANNEX

AMERICAN CLUB
MEDICAL HISTORY QUESTIONNAIRE

NAME ______________________________________ PHONE __________________________________
ADDRESS ____

BIRTHDATE ____/____/____ EMPLOYER ____
JOB TITLE ________________________________ SEAMAN CERTIFICATE NO.________________
VESSEL NAME____
IN CASE OF EMERGENCY, NOTIFY: __________________________ PHONE ________________
RELATIONSHIP ____
PERSONAL PHYSICIAN OR CLINIC ____
ADDRESS: ____
____

ALLERGIES: ____

FAMILY HISTORY Has anyone in your family ever had (check box if yes):

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

☐ Cancer ☐Mental Illness ☐ Epilepsy/Seizure

Any other major conditions? ____
____

If you answered "Yes" to any of the above, please explain: __________________________
____

Check the box if you have had or received medical treatment for:

Diabetes	☐ Yes	High Blood Pressure	☐Yes
Heart Trouble	☐ Yes	Rheumatic Fever	☐ Yes
Hernia	☐ Yes	Frequent Headaches	☐ Yes
Cancer/Tumor	☐ Yes	Dizziness	☐ Yes
Chronic Cough	☐ Yes	Shortness of Breath	☐ Yes
Chest Pain	☐ Yes	Varicose Veins	☐ Yes
Arthritis/Gout	☐ Yes	Asthma	☐ Yes
Kidney Trouble	☐ Yes	Tuberculosis	☐ Yes
Epilepsy	☐ Yes	Back Problems	☐ Yes
Rash or Skin Trouble	☐ Yes	Slipped Disc	☐ Yes
20/20 Vision	☐ Yes	Wrist Problems	☐ Yes
Hearing Problems	☐ Yes	Fractured Vertebrae	☐ Yes
Mental Breakdown	☐ Yes	Drug Problems	☐ Yes
Jaundice or Hepatitis	☐ Yes	Vision Problems	☐ Yes

Sexually Transmitted Disease ☐ Yes

Psychological Impairment, Depression or Mental Illness ☐ Yes

Date of last **tetanus shot**: ________________ (dd/mm/yyyy)

Date of last **dental cleaning**: ________________ (dd/mm/yyyy)

Date of recent **dental work**: ________________ (dd/mm/yyyy)

FEMALES ONLY

Pregnancy ☐ Yes   Menstrual Problems ☐ Yes

Breast Lumps ☐ Yes

MALES ONLY

Prostate Problems ☐ Yes   Penile Discharge ☐ Yes

Testicular Lumps ☐ Yes

Are you currently under a doctor's care? ____________

If Yes, for what problem(s)? ____

Physician(s) Name/Address (if different than noted on page 1): ________________________

____

Please list any surgeries/hospitalizations (reason for and date): _______________________

____

HABITS

Do you or did you smoke? _______ How long? _______ Packs per day? ______

Do you use alcoholic beverages? _______ How much/often? ______________

Do you use or take any drugs? _________ What kinds? __________

Please list prescription and over the counter medications you take regularly:

____

____

Would you say that your health is (please check one): ___ Excellent ____Good ____Fair

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 Insurers of the Vessel or their authorized representatives.