AMERICAN CLUB PRE-EMPLOYMENT MEDICAL EXAMINATION FORM—2019

IMPORTANT: The original of this form is to be kept by the seafarer. A copy must be kept by the clinic.

Date of Examination: _____/_____/_____ (dd/mm/yyyy)

PHOTOGRAPH

Name:			
	Last Name	**First Name**	**Middle Name**
Mailing Address:			
Date of Birth (dd/mm/yyyy)	**Blood Type/Group**	**Place of Birth (City/Country)**	**Name of Ship/Vessel**
Medical Certificate No.:		**Seafarer's Certificate No.:**	

Seafarer's Signature

NOTE: The passing or failure of the medical examinations for the following is based upon the 2019 *American Club Pre-Employment Medical Examination Guidelines*. All relevant examinations must be completed and recorded below.

Examination	Results of Examination		Examination	Results of Examination	
	Pass	Fail		Pass	Fail
1. Medical History Questionnaire (attached)	☐	☐	**13. Ultrasound examination** (presence of gall and/or kidney stones)	☐	☐
2. Physical Examination	☐	☐	**14. Hep B Antigen**	☐	☐
3. Dental Examination	☐	☐	**15. Hep C Antibodies**	☐	☐
~~**4. Psychological Test**~~	~~☐~~	~~☐~~	**16. VDRL**	☐	☐
5. Visual Test	☐	☐	**17. HIV Test**	☐	☐
6. Color Vision	☐	☐	**18. Stress Test**	☐	☐
7. Audiometry	☐	☐	**19. Diabetes**	☐	☐
8. Chest X-ray	☐	☐	**20. Fasting Blood Sugar**	☐	☐
9. Electro Cardiogram (ECG or EKG)	☐	☐	**21. Glycosylated Haemoglobin (HbA1c)**	☐	☐
10. Urinalysis	☐	☐	**22. Liver Function Test**	☐	☐
11. Fecalysis (food service/handlers only)	☐	☐	**23. Alcohol/Drug Test**	☐	☐
12.Complete Blood Count	☐	☐	**24. Spirometry**	☐	☐

If failed in any of the abovementioned examinations, please provide an explanation for the failure with the associated examination number:	
Exam #____	
Exam #____	
Exam #____	

Has medication been prescribed because of this PEME?	**YES**	☐	**NO**	☐	**If "YES", the *American Club PEME Declaration Form* MUST BE completed (third page).**

Name of Medical Clinic:	
Address of Medical Clinic:	
Contact Phone No.:	
Contact Fax No.:	
Name and Degree of Physician:	
Name of Physician's Licensing Body:	
Date of Issue of Physician's License:	
Date of Completed PEME Examination:	
Expiry Date for PEME: (cannot be less than one calendar year)	

Signature of Physician

American Club Hologram to be placed here

AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

IMPORTANT: This medical history form must be completed in the presence of the clinic physician.

American Club Hologram Sticker No. (from previous page):_____
Doctor's Initials: _____

PHOTOGRAPH

Name:			
	Last Name	**First Name**	**Middle Name**
Home Address:			
Date of Birth (dd/mm/yyyy)	**Phone No.**	**Seaman's Certificate No.**	**Employer**
In case of emergency, notify:		**Relationship:**	
Address:		**Phone No.:**	

Seafarer's Signature

Personal Physician or Clinic:		**Physician's Phone No.:**	
Address:			

Family History					
	YES	**NO**		**YES**	**NO**
Diabetes	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Mental Illness	☐	☐
Heart Disease	☐	☐	Epilepsy/Seizure	☐	☐

If "YES" to any of the above, please explain:_____
_____
_____

Any other major medical or physical conditions?_____
_____
_____

MALE ONLY	**YES**	**NO**	**FEMALE ONLY**	**YES**	**NO**
Prostate Problems	☐	☐	Pregnancy	☐	☐
Testicular Lumps	☐	☐	Breast Lumps	☐	☐
Penile Discharge	☐	☐	Menstrual Issues	☐	☐

If "YES" to any of the above, please explain:_____
_____
_____

	YES	**NO**
Are you currently under a doctor's care?	☐	☐
If "YES", for what problem(s)?		
Physician's name and address (if different from the one noted above)		
Have you had surgeries or have been hospitalized?	☐	☐
If "YES", provide the date(s) and give details below:		

Date of last Tetanus vaccination:		(dd/mm/yyyy)
List other vaccinations/dates:		
		(dd/mm/yyyy)
Date of last dental cleaning:		(dd/mm/yyyy)
Date of any recent dental work:		(dd/mm/yyyy)

Overall, would you say that your health is (please check only one):
☐ **Excellent** ☐ **Good** ☐ **Fair**

Have you received treatment for the following?					
	YES	**NO**		**YES**	**NO**
Diabetes	☐	☐	Jaundice or Hepatitis	☐	☐
Heart Trouble	☐	☐	Dizziness	☐	☐
High Blood Pressure	☐	☐	Back Problems	☐	☐
Shortness of Breath	☐	☐	Slipped Disk	☐	☐
Chest Pain	☐	☐	Wrist Problems	☐	☐
Chronic Cough	☐	☐	Fractured Vertebrae	☐	☐
Asthma	☐	☐	Arthritis/Gout	☐	☐
Tuberculosis	☐	☐	Kidney Problems	☐	☐
Rheumatic Fever	☐	☐	Cancer/Tumor	☐	☐
Frequent Headaches	☐	☐	Rash or Skin Problems	☐	☐
Vision Problems	☐	☐	Hernia/Hydrocele	☐	☐
20/20 Vision	☐	☐	Varicose Veins	☐	☐
Epilepsy/Seizure	☐	☐	Drug Problems	☐	☐
Hearing Problems	☐	☐	Mental Breakdown	☐	☐
Psychological Impairment, Depression or Mental Illness				☐	☐
Sexually Transmitted Disease				☐	☐

Allergies	**YES**	**NO**
Do you have any allergies?	☐	☐

If you have allergies, please describe: _____
_____
_____

	YES	**NO**	
Do you smoke?	☐	☐	If "YES", how long?
			If "YES", how many packs per day?
Do you drink alcohol?	☐	☐	If "YES", how much and how often:
Do you use or take any drugs?	☐	☐	If "YES", name the drugs and how often used:

Are you presently on any medication(s)?	**YES**	☐	**NO**	☐
If "YES", please list prescription and over the counter medications you take regularly:				

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 Insurance of the Vessel or their authorized representatives.

AMERICAN CLUB DECLARATION FORM —2019

IMPORTANT: If medication has been prescribed by the clinic, the seafarers BMI has been found to be between 30 and 32.9, or any other relevant medical condition requiring lifestyle changes has been found, as a condition of issuing this American Club PEME certificate, this form MUST BE completed by the clinic.

American Club Hologram Sticker No. (from first page)**:_____**

Doctor's Initials: _____

*I, _____, Seaman's Number _____, **Hereby Declare** that I understand that I have been issued an American Club pre-employment medical examination form according to the standards of American P&I club so that I may be employed on the understanding that I will be responsible for taking the following prescribed medication(s) (name(s) of prescribed medication(s)):*

……
……

In addition, the following medical recommendation have been given to me by the doctor for the medical condition of (name(s) of prescribed medication(s))

……
……

*(name of doctor(s), name of clinic, **this physician is required to sign this form at the bottom**)*

……
has explained to me what my condition is, what medication is required and how this should be administered.

I hereby agree to ensure that I follow taking prescribed medication and following medical recommendation given to me by the doctor and that I will take responsibility for making arrangements to secure the medication during the course of my employment as prescribed. Any additional medical evaluations and testing I may need because of the pre-existing condition are to my responsibility.

My signature below acknowledges my receipt and understanding of this Declaration and I that I had an opportunity to discuss any questions or concerns about this notice with a member of the PEME team and that my noncompliance with this undertaking have been fully explained to me and I confirm that I understand the same.

I have given the original of this Declaration to the medical facility where the American Club pre-employment medical examination form has been issued. I confirm to keep the copy of this Declaration through the term of validity of pre-employment medical examination form.

***Seafarer's Signature**: _____*

***Date**: _____(mm/dd/yyyy)*

Witnessed by:
(Physician's signature): _____