G910.03.2

Issue Date: October 5, 2012

POSITION:	**SEAFARER'S MEDICAL CERTIFICATE (Pre-employment, Re-employment, Biennial)**	DATE:	EXP. DATE:
SHIP:		NEW HIRE: Yes ☐ No ☐	

NAME: (Last)	(First)	Sex:	Date of Birth:	Nationality:

ADDRESS: (street)	City:	State:	Country:

This section to be completed by Medical Practitioner upon completion of Medical Exam:

In accordance with the provisions of ILO Maritime Labor Convention 2006 (MLC 2006), this medical certificate indicates that the above mentioned Seafarer has passed the below minimum requirements, and all are satisfactory.

	Satisfactory
Proper Seafarer's identification was provided and verified at the time of examination by the Medical Practitioner.	☐
Hearing, unaided hearing and visual acuity meet medical requirements.	☐
Color vision meets medical standards (where applicable to Seafarers whose jobs/duties are affected).	☐
Seafarer has been deemed Fit for Duty and free of any medical condition(s) likely to be aggravated by sea service.	☐
Approved Physician's Name and Signature provided	☐

This section to be completed by Seafarer taking Medical Exam:

HAVE YOU EVER HAD, DO YOU NOW HAVE, OR EVER BEEN TOLD THAT YOU HAVE/HAD ANY OF THE FOLLOWING:

CONDITION	Yes	No	CONDITION	Yes	No
1. Epilepsy/Seizures/Fainting	☐	☐	23. Rheumatic Fever/Typhoid Fever	☐	☐
2. Severe Headaches	☐	☐	24. Malaria	☐	☐
3. Heart Problems or Disease	☐	☐	25. Genetic or Familial Disorders	☐	☐
4. High or Low Blood Pressure	☐	☐	26. Amputations/Prosthetics	☐	☐
5. Chest Pain/Shortness of Breath	☐	☐	27. Arthritis/Hand or Wrist Problems or Pain	☐	☐
6. Tuberculosis	☐	☐	28. Sprains/Dislocations/Fractures	☐	☐
7. Asthma/Hay Fever/Allergies	☐	☐	29. Neck Pain/Neck Injury	☐	☐
8. Frequent Colds/Sore Throat	☐	☐	30. Back Pain/Back Injury	☐	☐
9. Pneumonia/Influenza/Bronchitis	☐	☐	31. Sciatica/Scoliosis/Rheumatism	☐	☐
10. Lung Problems or Disease	☐	☐	32. Bone or Joint Injury or Problems	☐	☐
11. Abdominal Pain/Ulcer/Stomach Problems or Disease	☐	☐	33. Degenerative Condition/Disease of the Back/ Neck/Muscles/Joints	☐	☐
12. Hepatitis/Gallbladder Stones/Liver Disease	☐	☐	34. Knee Problems/Leg Injury/Varicose Veins or Leg Swelling	☐	☐
13. Kidney Stones /Kidney Problems or Disease	☐	☐	35. Muscular Weakness	☐	☐
14. Diabetes/Thyroid Disease/Other Endocrine Problems or Diseases	☐	☐	36. Psychiatric illness/Counseling/Mental Disorder(s)	☐	☐
15. Prostate/Hernia/Other Urologic Conditions or Diseases	☐	☐	37. Drug usage/Excessive drinking/Failed drug test	☐	☐
16. HIV/Syphilis/Gonorrhea/Sexually Transmitted Diseases	☐	☐	38. Hospitalization/Surgical Operation	☐	☐
17. Abnormal Blood Studies/Cancer/Tumor(s)/ Abnormal Pap Test	☐	☐	39. Serious Injury/Serious Illness	☐	☐
18. Rashes/Skin Problems or Diseases	☐	☐	40. Elbow Pain/Elbow Injury	☐	☐
19. Head Injury/Stroke/Concussion	☐	☐	41. Foot/Ankle pain/injury	☐	☐
20. Vision/Eye Problems or Diseases	☐	☐	42. Shoulder pain/injury	☐	☐
21. Nose/Throat Problems or Diseases	☐	☐	43. Hip pain/injury	☐	☐
22. Ear Problems or Diseases/Deafness	☐	☐	44. Any Other Medical Conditions Not Listed Above	☐	☐
HAVE YOU EVER RECEIVED ANY OF THE FOLLOWING:			**HAVE YOU EVER BEEN:**		
45. Compensation/Disability for Job Injury	☐	☐	47. Refused Employment for Physical Reasons	☐	☐
46. Military Medical Discharge	☐	☐	48. Rejected for Military Service	☐	☐

NAME: (Last) (First) Date of Birth:

ARE YOU CURRENTLY:

CONDITION	Yes	No	CONDITION	Yes	No
49. Under a doctor's care?	☐	☐	50. Taking medicines?	☐	☐
51. Have you taken any medications/injections over the past 12 months?				☐	☐
52. Do you Drink Alcohol? If yes, how much per day?				☐	☐
53. Do you Smoke? If yes, how much per day?				☐	☐

IF ANY OF THE ABOVE ANSWERS (1-53) IS MARKED **"YES"** YOU MUST EXPLAIN BELOW:

I AFFIRM THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST TO MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT I MUST DISCLOSE ALL MEDICAL CONDITIONS WHICH MIGHT AFFECT MY EMPLOYMENT, WHETHER LISTED ABOVE OR NOT. I ALSO AGREE TO CONTINUOUSLY UPDATE NORWEGIAN CRUISE LINE WITH ANY AND ALL MEDICAL INFORMATION THAT MAY ARISE SUBSEQUENT TO THE DATE OF THIS DOCUMENT. IF I FALSIFY OR FAIL TO DISCLOSE ANY MEDICAL CONDITION/INFORMATION, AND/OR FAIL TO PROVIDE NORWEGIAN CRUISE LINE WITH UPDATED INFOMRATION AS NECESSARY SUBSEQUENT TO THE DATE OF THIS DOCUMENT, SUCH ACTION OR INACTION WILL SERVE AS GROUNDS FOR TERMINATION WITHOUT EMPLOYMENT BENEFITS AND/OR MAINTENANCE AND CURE. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION CONCERING MY PAST, PRESENT OR FUTURE MEDICAL CONDITION, BY ANY PRACTITIONER OR HOSPITAL, TO NORWEGIAN CRUISE LINE OR THEIR REPRESENTATIVES.

I AM ABLE TO READ, WRITE AND SPEAK ENGLISH, AND I FULLY UNDERSTAND THE ABOVE QUESTIONS.

Applicant's signature (Required): _____

This section to be completed by Medical Practitioner performing Medical Exam:

EXAMINATION

Name/Address of Examining Facility (Type or Print) _____

Name of Medical Practitioner performing examination (Type or Print) _____ (MD/DO)

a. TEMPERATURE: HEIGHT: WEIGHT: PULSE: BLOOD PRESSURE:
b. DISTANT VISION: WITHOUT GLASSES RIGHT 20/ LEFT 20/ WITH GLASSES RIGHT 20/ LEFT 20/
NEAR VISION: WITHOUT GLASSES RIGHT 20/ LEFT 20/ WITH GLASSES RIGHT 20/ LEFT 20/
c. COLOR VISION: RIGHT: LEFT: (Date:)

Did the Doctor review the above medical history with the applicant? ☐**Yes** ☐**No**
Did the applicant have the ability to understand? ☐**Yes** ☐**No**

	ABNORMAL	NORMAL		YES	NO
1. EYES (pterygiums?)	☐	☐	11. EXTREMITY ABNORMALITY	☐	☐
2. EAR DRUMS/HEARING	☐	☐	12. REFLEX ABNORMALITY	☐	☐
3. NOSE	☐	☐	13. SKIN ABNORMALITY	☐	☐
4. THROAT/MOUTH	☐	☐	14. HERNIA	☐	☐
5. NECK	☐	☐	15. RECTAL ABNORMALITY	☐	☐
6. HEART MURMURS/RHYTHM	☐	☐	16. BACK ABNORMALITY	☐	☐
7. LUNGS AND CHEST	☐	☐	17. VARICOSE VEINS/VASCULAR SYSTEM	☐	☐
8. ABDOMEN/ORGAN ENLARGEMENTS	☐	☐	18. DEFORMITIES/LIMITATION OF MOTION	☐	☐
9. GENITOURINARY (Pelvic only if indicated)	☐	☐	19. FOOT ABNORMALITY/BUNIONS	☐	☐
10. PSYCHIATRIC BEHAVIOR	☐	☐	20. SCARS ON BACK/KNEES/ELSEWHERE	☐	☐

REQUIRED LABORATORY TESTS

a. Chest X-Ray: Normal _____ Abnormal _____
b. Drug Screen: THC _____ COC _____ AMPH _____ OPIATES
c. Serology: Non-reactive _____ Reactive _____
d. Pap Smear (female): Negative _____ Intermediate _____ Positive _____
e. Urinalysis: Normal _____ Abnormal _____
f. HBSAG: Positive _____ Negative _____
g. Stool Ova/Parasites (food handlers): Positive ___ Negative ___

REMARKS (print):

PHYSICAL CLASSIFICATION

EMPLOYABLE (Fit for Duty) _____ ☐
(Normal exam, neg. drug screen, no pre-existing conditions)
Date of Examination _____

REFER TO NCL FOR APPROVAL _____ ☐
Non-employable (Not Fit for Duty) _____ ☐
Medical Practitioner's Signature _____ (MD/DO)