



Certificate No: 9987

REPUBLIC OF KENYA

## SEAFARER MEDICAL CERTIFICATE

Issued under Regulation 6 of the Merchant Shipping (Seafarer Medical Examination and Certification) Regulations, 2016

## SEAFARER INFORMATION

Last name: MUCHIRI		First name: KATHLEEN		Middle name(s): WANJIRU	
Nationality: KENYAN		Passport No:		Date of Birth: 03/05/1995	
Discharge book No:		Gender: Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		Rank/Job: COOK	
Department: F & B					

This is to certify that above named seafarer has been examined in accordance with the Seafarers' medical fitness standards and certification requirements established in accordance with the provisions of regulation 1/9 of the STCW Convention, 1978 as amended, and regulation 1.2, Maritime Labour Convention, 2006 as amended and found to be fit for sea service, subject to any limitations indicated

## DECLARATION OF THE RECOGNIZED MEDICAL PRACTITIONER

	Yes	No
1. Confirmation that identification documents were checked at the point of examination	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Hearing meets the standards in STCW Code Section A-I/9? Date of test (dd/mm/yyyy): 21/10/2022	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Unaided hearing satisfactory?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Visual acuity meets standards in section A-I/9? Visual aids (if worn) <input type="checkbox"/> Spectacles <input type="checkbox"/> Contact lenses <input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Colour vision meets standards in section A-I/9? Date of last color vision test: 21/10/2022	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Fit for look-out duties? (Deck and Engine Dept. only)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Limitations or restrictions on fitness?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If "Yes", specify limitations or restrictions:		Examination form No:
8. Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Date of Issue (dd/mm/yyyy): 21/10/2022	Date of Expiry* (dd/mm/yyyy): 20/10/2024	
<b>RECOGNIZED MEDICAL PRACTITIONER</b> Sign: _____ Name (print): DR. RISHAD ALI SHOSI Place of examination: MOMBASA HOSPITAL Seal/Stamp: _____		<b>REGISTRAR OF KENYAN SEAFARERS</b> Sign: _____ Name (print): LUKE SAMBA Place of issue: _____ Seal/Stamp: _____ P. O. Box 98075, U4, MOMBASA, KENYA.

**SEAFARER'S DECLARATION:** I hereby confirm that I have been informed about the content of this certificate and my right to appeal in accordance with the Merchant Shipping (Seafarer Medical Examination and Certification) Regulations, 2016.

Signature of the seafarer: \_\_\_\_\_ \*Valid for a maximum period of two years unless the seafarer is under the age of 18, in which case the maximum period of validity shall be one year.



## MERCHANT SHIPPING (MEDICAL EXAMINATION) REQUEST FORM

Regulation 7

### Medical Examination Request Form (To be completed by the seafarer or employer)

To:

Dr. :

Address:

Telephone:

Date:

Rishad A.S

90106-80100

0222704470

21/10/22

Please carry out a  Pre-sea\*  Periodic\*  Other\* health assessment of .....

For the position of .....

Yours sincerely,

Please keep all the Medical Examination forms in your confidential files in accordance with normal medical practice and return a copy of the certificate of Medical Fitness together with your account to:

Name: .....

Position: .....

Address: .....

Phone: .....

Fax: .....

\*delete where not applicable



Work at sea requires physical effort within the limits set by applicable international health and safety legislation and standards.

**This may include exposure to:**

Noisy work environment  
Communication by radio  
Handling solvents, oils, grease or paint  
Manual work e.g lifting, pulling, reaching, shovelling.  
Reaching, shovelling  
Prolong sitting/standing

Hot environment or cold environment  
Working at height up to 30 metres

# MEDICAL EXAMINATION REPORT

## Regulation 9

### PART- A TO BE COMPLETED BY APPLICANT

You should complete this section before you go for your medical examination.

You must take a suitable means of identification (national ID, passport, certificate of competency, driving licence) with you to the examination.

Name:

First Name	Last Name
KATHLEEN	MUCHIRI

PIN:

Date of Birth

Male

Female

Home Address:

### PRIVACY NOTE

Please read carefully for information and guidance

The information contained on this form and its associated documents will be used for the purposes of assessing your medical fitness for duty at sea and for KMA audit purposes. This information may be exchanged between your examining medical officer and your treating medical practitioner and/or any medical panel convened to assess your fitness for duty at sea. If you do not meet the medical fitness standard for duty at sea, you and your employer will be advised of this on the Certificate of Medical Fitness.

Are you taking any medications at present?  Yes  No

Do you have or have you had an eye disorder or injury.  Yes  No

NOTE: If you wear glasses, corneal or contact lenses, bring them with you to the examination. CHROMAGEN LENSES MUST NOT BE WORN

# PERSONAL HISTORY

**Position on board vessel:**

- Deck Officer       Engineer Officer     Catering  
 Integrated             AB/Deck Rating  
 Engine Room Rating\*    Other (eg Entertainer)

Are you in good health now?       Yes     No

Do you drink alcohol?             Yes     No

If yes, how much and how often?

Do you smoke tobacco?             Yes     No

If no, have you smoked in the past?     Yes     No

Have you been absent from work due to sickness or injury for more than 14 consecutive days over past two years?     Yes     No

**Have you now, or have you previously had any of the following:**

- Anxiety or depression             Yes     No
- Migraine or persistent headaches     Yes     No
- Epilepsy or fits                     Yes     No
- Poliomyelitis or other paralysis     Yes     No
- Attack of unconsciousness or weakness,     Yes     No
- dizziness or turns                  Yes     No

Have you ever been declared unfit for duty at seas?                             Yes     No

If yes, state when, for how long and for what reason

Has your certificate of medical fitness ever been restricted or cancelled or have you ever declared unfit?     Yes     No

If yes, give details

**Have you ever been signed off as sick or repatriated from a ship?**

- Discharge from ears or perforated eardrum     Yes     No
- Ringing in the ears or disturbances of balance     Yes     No
- Deafness                             Yes     No
- Nasal or sinus trouble             Yes     No
- Persistent husky voice or frequent sore throat     Yes     No
- Goitre or Thyroid disease          Yes     No

**Have you now, or have you previously had any of the following:**

- High blood pressure  Yes  No
- Disease of the heart, arteries or blood vessels  Yes  No
- Operation of the heart  Yes  No
- Anaemia or any other disease of the blood  Yes  No
- Swelling of the ankles  Yes  No
- Palpitations  Yes  No
- Varicose veins or abnormal bleeding  Yes  No
- Rheumatic fever  Yes  No
- Disease of the liver (including jaundice or hepatitis)  Yes  No
- Disease or ulcer of the stomach or duodenum  Yes  No
- Recurrent abdominal pain/persistent indigestion  Yes  No
- Appendicitis  Yes  No
- Gallbladder disease  Yes  No
- Disease of the bowels  Yes  No
- Haemorrhoids (piles)  Yes  No
- Hernia (rupture)  Yes  No
- Recent change in weight  Yes  No

**Have you now, or have you previously had any of the following:**

- Asthma  Yes  No
- Bronchitis or emphysema  Yes  No
- Tuberculosis  Yes  No
- Persistent breathlessness  Yes  No
- Persistent cough  Yes  No
- Collapsed lung  Yes  No
- Other lung disease/abnormal x-ray  Yes  No
- Infection of bladder  Yes  No
- Kidney disease or kidney stone  Yes  No
- Difficulty in passing urine  Yes  No
- Any abnormality of the urine  Yes  No
- Sexually transmitted disease  Yes  No

- Any form of cancer or unexplained lumps  Yes  No
- Diabetes  Yes  No
- Dermatitis/eczema/skin eruptions  Yes  No
- Allergy conditions including hay fever  Yes  No
- Any abnormality of the immune  Yes  No
- Any allergic reaction to any serum, drug or medicine (including anaesthetic agents) and vaccines.  Yes  No
- Any disease such as malaria, typhoid, amoebiasis, giardia etc  Yes  No
- Severe tooth or gum trouble  Yes  No
- Impacted wisdom teeth  Yes  No
- Any obstetric or gynaecological problems  Yes  No
- Are you pregnant?  Yes  No

**Please give details of any complaint, illness or injury not previously mentioned**

Are you aware of ANY circumstances regarding your health which may interfere with the satisfactory discharge of the duties of your designated position / occupation?

Yes  No

If yes, give details

- Lumbago, sciatica or other back trouble
- Any form of arthritis or stiff joints
- Joint injuries
- Injury of the neck or back

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No


- Repetitive Strain Injury, tennis elbow, tendonitis
- Broken bones
- Gout

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

**The following should be signed in  
the presence of the examining medical officer**

**Declaration**

I hereby declare that, to the best of my knowledge my personal statements are true and correct

Applicant's Signature:  .....

Date: 21 / 10 / 22

**Authority to divulge medical information**

If, as a result of this subsequent examinations for the purposes of assessing my medical fitness for duty at sea, the examining medical officer requires relevant medical details from my treating medical advisor (s), permission is hereby granted to obtain information from:

Dr. : Parshad A.S .....

Dr. : .....

Address: 90106-80100 .....

Address: .....

Phone: 0722704470 .....

Phone: .....

Dr. : .....


Dr. : .....

Address: .....

Address: .....

Phone: .....

Phone: .....

Applicant's Signature:  .....

Date: 21 / 10 / 22

**PART- B**  
**TO BE COMPLETED BY MEDICAL EXAMINER**

Medical Examiner's name	Telephone number
DR. RISHAD A.S	0722704470

**Applicant's proof of identity**

- Photo driver's licence  
 Passport  
 Other .....

Passport/Driving Licence No.
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**Applicant's position on board vessel**

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Note: Requirements regarding hepatitis, colour, vision etc will depend on the applicant's position on board vessel, please Refer to the Guidelines

**HEIGHT/WEIGHT (See Guidelines-PAGE 3)**

Height (without shoes) ..... 1.66 ..... Metres  
 Weight ..... 65 ..... Kg  
 Body Mass Index (BMI) = (Height in m)<sup>2</sup>

**VISION (See Guidelines-PAGE 3)**

Is there any visual defect of the eyes?  Yes  No

The visual acuity of each eye should be tested with Snellen's Charts and The results recorded:

	Unaided			Aided		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant	6/6	6/6				
Near	6/6	6/6				

**Visual fields to confrontation**

	Normal	Defective
Right eye	Normal	
Left eye		

Please refer to the 'Guidelines for the medical examination of seafarers and coastal pilots available at: <http://www.maritimeauthority.co.ke>

**SPEECH/HEARING/BALANCE (See Guidelines – Page 4)**

- Is there any defect in speech? Yes  No   
 Is there any disease of the ears? Yes  No   
 Is there any defect in hearing? Yes  No   
 Romberg's test normal? Yes  No

	500 Hz	100 Hz	200 Hz	300 Hz	400 Hz	600 Hz
Right ear	Normal					
Left ear						

**Conversion Test at 3 Mtrs**

Conversion test only required if hearing loss in the better ear is more than 40dB at 500 to 2000Hz

	Speech
Both Ears	/10

**CARDIOVASCULAR (See Guidelines – Page 5)**

Pulse: ..... 62 ..... /Min Rhythm: ..... Regular .....  
 Blood Pressure readings: Systolic ..... 123 ..... Diastolic ..... 65 .....  
 If this reading is above 150/95 please take further readings after rest.

Heart sounds/apex beat Normal  Abnormal

Is there any history or evidence of taking anti-hypertensive medication? Yes  No

**ECG Report (Attach report and tracing to this form).**  
 (Stress ECG required if clinically indicated. Baseline tracing only to be attached to this document)

Date of ECG: ..... 21/10/12 .....

ECG results	Normal
Stress ECG result (if clinically indicated)	



**Colour vision**

Colour vision need not be tested if a test has been completed within the previous 6 years.

Date of last colour vision test if not Tested at this examination *Done*  *Normal*

Does the application suffer from any degree of colour blindness as Determined by Ishihara plates?

Ishihara test  Further test needed

Show number of plates with errors

Lantern test  Required  Notrequired

Does the applicant suffer from oedema or varicose veins?  Yes  No

If yes, state severity: .....

Are carotid/peripheral pulses normal?  Yes  No

Are you satisfied that the cardiovascular system is clinically within normal limits?  Yes  No

If no give, give reasons in full

**RESPIRATORY** (See Guidelines – page 6)

**Coloured wires test:**

In good lighting Pass  Fail  N/A

Further testing on board ship Pass  Fail  N/A

**Trachea:**

Chest expansion *3*cm  Abnormal

Breath sounds Normal  Abnormal

**Spirometry**

	Actual	Predicted	% Predicted
FEV1			
FVC			
FEV1/FVC			

Spirometry FEV1 < 65% requires further review  
 FVC < 70% requires review  
 FEV1/FVC < 70% requires review

**NEUROLOGICAL/PSYCHIATRIC** (See Guidelines-page 9)

Is there any evidence of organic disease of the brain, spinal cord or nerves?  Yes  No

Is there any evidence of mental or nervous disorder including psychoses?  Yes  No

Is there any evidence suggestive of anxiety Panic disorder or personality disorder?  Yes  No

**MUSCULOSKELETAL** (See Guidelines – page 10)

Does the applicant have normal use of the Legs and arms?  Yes  No

Are there any missing limbs or digits?  Yes  No

Is gait normal?  Yes  No

Are the bones and joints free of any defects?  Yes  No

Are joint movements in normal range and pain free?  Yes  No

Any restriction or pain in movement of spine?  Yes  No

Chest X-Ray report Normal  Abnormal

Chest X-rays are required for pre-sea medicals or if clinically indicated.

Date: 21 / 10 / 22  
(attach report to this form)

If, after examination you are not satisfied with the clinical condition and Efficiency of the respiratory system and chest give reasons

[Empty box for reasons]

**MOUTH/TEETH** (See Guidelines – page 7)

Is there disease, or abnormality of the Mouth, throat or neck?  Yes  No

of the Mouth, throat or neck?  Yes  No

Are there any defects in teeth?  Yes  No

Are there any disease of the nose or sinuses  Yes  No

**GASTROINTESTINAL / RENAL** (See Guidelines – page 7)

Is there any disease or abnormality of the abdominal organs?  Yes  No

If yes, give details

[Empty box for details]

Is there any hernia present?  Yes  No

Is the liver enlarged?  Yes  No

Any renal bruits?  Yes  No

**Urine dipstick Results:**

Glucose Normal  Abnormal

Protein Normal  Abnormal

Blood Normal  Abnormal

Other .....

Hepatitis A, previously vaccinated?  Yes  No

If yes, date of last vaccination [Empty box]

If no, results of blood test [Empty box]

Hepatitis arrangements apply to applicants who have a position on board Marked with an\* on the front page of this form.

**SKIN /LYMPH NODES** (See Guidelines – page 12)

Is there any skin disease, including solar Keratoses, BCCs, eczema etc  Yes  No

Are there any significant scars, ulcers, or Enlarged lymph nodes?  Yes  No

Are there any skin grafts?

Are there any identifying marks on the skin?  Yes  No

Medical Inspector's signature [Signature] Date 21/10/22



**ATTACH ALL TEST DOCUMENTS TO THIS REPORT**

• CHEST X-RAY REPORT  
(For pre-sea medicals or if clinically indicated)

• ECG TRACING  
(For applicants aged 55 years or more and/or if clinically indicated)

• ECG REPORT  
(Confirmed automatic machine report, or report by FRACGP or appropriate specialist).

• STRESS ECG  
(If clinically indicated)

• AUDIOGRAM REPORT  
(If clinically indicated).

A copy of this report is to be forwarded by the Medical Inspector to KMA after the examination is completed.

