

FREIGHTER PASSENGER MEDICAL CERTIFICATE OF HEALTH



Please use capital letters

Vessel Name:	Expected Date of Departure:	Duration:
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This certificate is mandatory for all freighter passengers. It is to be **completed and signed by the passenger's physician not more than 30 days prior to expected embarkation date**, attesting to the fact that:

A) The Passenger (full Name) : _____ **Age:** _____
is in good health and able to travel on a freighter that does not have a doctor onboard.

Yes No

B) Is this passenger infirm by reason of age or illness?

Yes No

C) Has this passenger had a previous history of:

Remarks

- | | | | |
|---|------------------------------|-----------------------------|-------|
| 1) Dizziness, fainting or unconscious spells? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 2) Nervous or mental disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 3) Tuberculosis or any chest or lung disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 4) Disorder of heart or blood pressure? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 5) Numbness, weakness or swelling of lower extremities? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 6) Diabetes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 7) Stomach ulcers, duodenal ulcer or peptic ulcer? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 8) Gall bladder or kidney disorders? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 9) Impaired vision or hearing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 10) Need for use of cane, crutches, wheelchair? * | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 10a) Has the passenger joint replacements (hip/knee)? ** | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 11) Is the passenger allergic? To What? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 12) Is the passenger allergic to any medication? Which? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 13) Is the passenger on any medication? Which? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| 14) If yes, is assistance required in taking this medication? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |

Further remarks:

I have been this patient's doctor for/since _____ **Address / stamp:**

Telephone-Nr: _____

Place/Date: _____ **Doctor's signature:** _____

* Persons who need a cane, crutches, wheelchair, artificial limbs or the assistance of any other person to move about cannot be accepted for passage. Passengers must be able to walk and care for themselves unaided.

** Persons with joint replacements may experience pain due to vibrations on freighters that can considerably affect the mobility. In serious cases subject passengers may have to be excluded from continuation of their passage.