FOLLOWING INSTRUCTIONS

- PANAMA APPLICATION FORM, signature has to be in **BLACK INK.**
- PICTURE, has to be a copy **COLOR** with **WHITE BACKGROUND**, **without glasses and facing in front**. Have to be in **JPEG.**
- MEDICAL CERTIFICATE, **select the position** on board (**RATING** for the Marine Technician fixed Platform), have to **be signed by the marine technician**, **by the doctor and stamped**. Have to make a CIRCLE on the certificate selecting : HE/SHE IS FOUND TO BE FIT. The EXPIRATION DATE is required. It is accepted ONLY medical certificate issued by governments.
- PASSPORT, has to be a **copy color and the double page including the signature**.
- COMPANY LETTER, need a sentence saying: **THIS LETTER IS VALID FOR ONE YEAR**
- PDF file scan **ONE BY ONE**.

MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD

SURNAME:	GIVEN NAME (S):	
DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH CITY COUNTRY	SEX MALE ☐ FEMALE ☐
POSITION ON BOARD: MASTER ☐ DECK OFFICER ☐ ENGINEERING OFFICER ☐ RADIO OPERATOR ☐ RATING ☐	MAILING ADDRESS OF APPLICANT:	

Select Position

DECLARATION OF THE AUTHORIZED PHYSICIAN

VISION			COLOR TEST TYPE	HEARING
	WITHOUT GLASSES	WITH GLASSES	☐ BOOK	
RIGHT EYE	____	____	☐ LANTERN	RIGHT EAR ____
			YELLOW ____ RED ____	
LEFT EYE	____	____	GREEN ____ BLUE ____	LEFT EAR ____

Confirmation that identification documents were checked at the point of examination: YES ☐ NO ☐

Hearing meets the standards in STCW Code, Section A-1/9? YES ☐ NO ☐ NOT APLICABLE ☐

Unaided hearing satisfactory? YES ☐ NO ☐

Visual acuity meets standards in STCW Code, Section A-1/9? YES ☐ NO ☐

Colour vision meets standards in STCW Code, Section A-1/9? YES ☐ NO ☐
(the visual test it is required every six years)
Date of the last colour vision test: (Day/Month/Year) ____/____/____ .

Are glasses or contact lenses necessary to meet the required vision standards? YES ☐ NO ☐

Able for watchkeeping? YES ☐ NO ☐

Is applicant taking any non-prescription or prescription medications? YES ☐ NO ☐

Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarers unfit for such service or to endanger the health of other persons on board? YES ☐ NO ☐

Signature Name, Date

Hereby I declare that I am in knowledge of the contents of the Physical Examination.

Signature of Applicant	Name of Applicant	Date

Circle : HE/SHE FOUND TO BE FIT

CIRCLE APPROPIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFCIER / ENGINEERING OFFICER / RADIO OPERATOR / RATING) (WITHOUT ANY / WITH THE FOLLOWING) RESTRICTIONS:

_____

_____

Name, Address

NAME AND DEGREE OF PHYSICIAN: _____

ADDRESS: _____

NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: _____

DATE OF ISSUE PHYSICIAN'S CERTIFICATE: _____

Signature Stamp, Date, Expiration date

SIGNATURE OF PHYSICIAN:	STAMP OF PHYSICIAN:	DATE:

EXPIRY DATE OF CERTIFICATE:

This certificate is issued in compliance with the requirements of the STCW Convention, 1978, as amended and the Maritime Labour Convention, 2006.

mariteam