



SFC-005

*STCW 1978 as amended.*

**MEDICAL FITNESS CERTIFICATE FOR PERSONNEL SERVICE ON BOARD  
BELIZEAN REGISTERED SHIPS**

Last name:	Given name(s):
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Position Onboard:			
Place of birth (City, Country)	Mailing address of Applicant (street, City, Country):	Date of Birth (dd/mm/yy)	Sex: M <input type="checkbox"/> F <input type="checkbox"/>

This Certificate is issued in accordance with the provisions of regulation I/9 of the STCW Convention 1978 as amended, and Regulation 1.2 of the Maritime Labor Convention, 2006

**DECLARATION OF THE AUTHORIZED PHYSICIAN**

Confirmation that identification documents were checked at the point of examination:	yes: <input type="checkbox"/> No: <input type="checkbox"/>
Hearing meets the standards in STCW Code, Section A-1/9?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
Unaided hearing satisfactory?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
Visual acuity meets standards in STCW Code, Section A-1/9?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
Colour vision meets standards in STCW Code, Section A-1/9?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
<i>The visual test is required every six years</i> Date of the last colour vision test	(Day/Month/Year):
Are glasses or contact lenses necessary to meet the required vision standards?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
Able for watchkeeping?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
Is the applicant taking any non-prescription or prescription medication?	yes: <input type="checkbox"/> No: <input type="checkbox"/>
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?	yes: <input type="checkbox"/> No: <input type="checkbox"/>

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

_____	_____	_____
Name of Applicant	Signature of Applicant	Date

Circle the appropriate choice:

(HE /SHE) is found to be (FIT /NOT FIT) for duty as a (WITHOUT ANY/WITH THE FOLLOWING) restrictions:

\_\_\_\_\_

\_\_\_\_\_

Front



(version)

STCW 1978 as amended.

Name and Degree of Physician: \_\_\_\_\_

Full address: \_\_\_\_\_

Name of Physician's certifying authority: \_\_\_\_\_

Issuance date of Certificate: \_\_\_\_\_

	Stamp of Physician:		
<input type="text"/>		Date: _____	
Signature of Physician		(Day/Month/Year)	

Expiration Date of Certificate: \_\_\_\_\_

*(This certificate cannot be valid for more than 2 years)*

*If the period of validity of this certificate expires in the course of the voyage, then the medical certificate shall continue in force until the next port of call where a medical practitioner recognized by IMMARBE is available, provided that this period does not exceed 3 months.*

**IMPORTANT NOTE**

The original or a certified copy of this certificate must be carried on board in accordance with regulation 1/2, paragraph 11 of the revised STCW Convention by the seafarer while serving on board of any Belize Flag vessel in order to prove that he/she is medically fit to serve in the aforementioned capacity.

**DETAILS OF MEDICAL EXAMINATION**  
*(To be completed by examining physician)*