

CONFIDENTIAL MEDICAL REPORT FORM

For ships under the flag of ANTIGUA AND BARBUDA

In accordance with Title 4 (Standard A4.1.2) of the Maritime Labour Convention 2006 and Antigua and Barbuda DMLC Part I- 12(b)

When completed this form shall be retained onboard and used only to facilitate proper medical treatment for the seafarer. The original of this form should accompany the seafarer for treatment ashore and be returned to the ship after treatment.

Ship and Location details

Name of ship:

IMO Number:

Shipowner (as per MLC Certificate):

Contact details of Ships representative/agent onshore (if applicable):

Location (Lat/Long or Port) at the onset of illness or injury:

Next Port:

ETA (date):

Seafarer (Patient) details:

Full Name:

Sex:

Male

Female

Date of Birth:

Nationality:

Position/Rank:

Seafarers ID no:

Passport

Discharge Book

other

Date and time off from work:

returned to work:

Details of illness or injury

Date and time of injury or onset of illness:

Date and time of first examination onboard:

Findings of onboard examination

Symptoms

Treatment received on board ship (enclose attachments if necessary)

Condition of patient after treatment

Medical Advice required: Yes

No

Shore treatment required:

Yes

No

MEDIVAC required: Yes

No

Date and Time MEDIVAC undertaken:

Masters Full Name:

Masters Signature:

Date:

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For completion by hospital or examining doctor on shore

Diagnosis:

Treatment given (generic names of drugs, dosage, route of administration):

Further doctor’s visit required: Yes No Suggested date of next examination:

Estimated duration of illness or injury (Days):

Completed if FIT FOR WORK

Fit for work now Fit for normal work from Date:

Fit for restricted work Specify:

Completed if UNFIT FOR WORK

Unfit for work now Estimates duration (days):

Bed rest required Estimates duration (days):

Patient should leave the ship and be: Hospitalized Repatriated

Patient May travel by Air Unaccompanied Only with medical escort

Medical treatment required at final destination:

Declaration by Doctor

Date of examination: Charge for this examination:

Payment received Yes No Doctors Signature and Stamp:

Full Name, Address and Telephone of Doctor (in capital letters)