Maritime & Coastguard Agency

CONFIDENTIAL MEDICAL REPORT

IN ACCORDANCE WITH TITLE 4 (STANDARD A4.1.2) OF THE MARITIME LABOUR CONVENTION, 2006

The personal information collected on this form will only be processed by authorised ship's Officers or land based medical provider for purposes of facilitating emergency medical treatment. Anyone that processes this form shall duly observe all of their obligations under the Data Protection Act and the General Data Protection Regulations. 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 vessel after treatment.

1 Vessel and Location Details

Vessel Name: IMO Number:

Vessel Owner: Flag of Vessel:

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

Next Port: ETA (Date):

2 The Seafarer (Patient)

Full Name: Sex: Male ☐ Female ☐

Date of Birth: Nationality:

Identity Document Number: Passport ☐ Discharge Book ☐ Other ☐

Position/Rank:

Date and Time off work: Returned to work:

3 The Injury or Illness

Date and time of injury or onset of illness:

Date and time of first examination onboard:

Symptoms: Findings of onboard examination:

Treatment administered onboard: Condition of patient after treatment:

Medical Advice Obtained: Yes ☐ No ☐ Shore Treatment Recommended: Yes ☐ No ☐

MEDIVAC Arranged: Yes ☐ No ☐ Date and time MEDIVAC undertaken:

Master's Full Name:

Date:

Master's Signature

4 Remote Medical Assistance (If Required)

Name of Medical Advisor: TMAS Centre:

Date and time of first contact with medical advisor:

Medical Advice Received:

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5 For use by the examining Doctor

After examination of the patient, please complete this form and return to the vessel's master (or local agent). Please enclose all relevant medical reports when returning this form.

Diagnosis:

Treatment or Medication Administered:

Further Treatment or Medication Required:

Further Doctors Visit Required: Yes ☐ No ☐ Suggested Date for Next Examination:

Estimated duration of illness or incapacity (Days):

6 To be completed if Patient is FIT FOR WORK

Fit for work now ☐ Fit for work from ☐ , Date: Fit for work with restrictions ☐

Details of any restrictions on work:

7 To be completed if Patient is UNFIT FOR WORK

Unfit for work now ☐ Estimated Duration (Days):

Bed Rest Required ☐ Estimated Duration (Days):

The patient should leave the vessel ☐ and be: Admitted to Hospital ☐ Repatriated ☐

Patient May Travel by Air ☐ Unaccompanied ☐ Only With Medical Escort ☐

Medical Treatment Required at Final Destination:

8 Declaration by Doctor

Date of this Medical Examination:

Charge for Examination: Payment Received: Yes ☐ No ☐

Full Name, Address and Telephone of Doctor:

Doctor's Signature

Doctors' Stamp