



KIRIBATI SHIP REGISTRY

Application for Medical Fitness Examination

* Select as appropriate.

Applicant's Particulars				
Name in Full (Block Capitals)				Passport No:
Date of Birth:	Place of Birth:	Nationality:	Sex *:	Rank:
			<input type="checkbox"/> Male / <input type="checkbox"/> Female	
Address:			Tel no:	
			Email Address:	

Doctor's Examination Report

1	Height/Weight		Metres		Kilos	
2	Hearing		Right		Left	
3	Eyesight		Right		Left	Color Vision
4	Urinanalysis		Sugar		Albumin	Microscopy
5	Full blood count		Hb		WBC	Platelets
6	VDRL		Negative		Positive	
7	Chest X-Ray Report (last X Ray within a year)		Normal		Abnormal	
8	Electrocardiogram (ECG) (EDG)		Normal		Abnormal	
9	Pulse		Per min			
10	Blood Pressure					

		Normal	Abnormal	If abnormal gives details
11	Cardiovascular system	<input type="checkbox"/>	<input type="checkbox"/>	
12	Central Nervous system	<input type="checkbox"/>	<input type="checkbox"/>	
13	Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	
14	Locomotor system (spine/limbs)	<input type="checkbox"/>	<input type="checkbox"/>	
15	Skin (including varicosities)	<input type="checkbox"/>	<input type="checkbox"/>	
16	Physique –Deformities	<input type="checkbox"/>	<input type="checkbox"/>	
17	Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>	
18	Intelligence, mental state	<input type="checkbox"/>	<input type="checkbox"/>	
19	Gastrointestinal system (eg Hernia)	<input type="checkbox"/>	<input type="checkbox"/>	
20	Urogenital system (eg Hydrocoele)	<input type="checkbox"/>	<input type="checkbox"/>	
21	Endocrine system (eg Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	
22	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
23	Ears/ Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	
24	Mouth/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	

Doctor's Remarks & Declaration

Certificate of Medical Fitness			
I certify that I have examined Mr. _____, NRIC / PP No _____ to the medical standards of the Kiribati Ship Registry and found him/her FIT/UNFIT.			
Remarks (if any) _____			

Official Stamp	Date of Examination	Signature & Name of Doctor	Name of Medical Institute/Hospital