CONFIDENTIAL MEDICAL REPORT

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

Maritime Authority of the Cayman Islands
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Email: crew.compliance@cishipping.com
Website: www.cishipping.com

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.

1 Ship and Location Details

Ship's Name: IMO Number:

Shipowner (as per DMLC Part II):

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 Required: Yes ☐ No ☐ Shore Treatment Required: Yes ☐ No ☐

MEDIVAC Required: 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:

Date and time of first contact with medical advisor:

Medical Advice Received:

Cayman Maritime

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5 FOR USE BY THE EXAMINING PHYSICIAN

After examination of the patient, please complete this form and return to the ship'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:

Futher Physicians Visit Required: Yes ☐ No ☐ Suggested Date for Next Examination:

Estimated duration of illness or incapacity (Days):

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:

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 ship ☐ and be: Admitted to Hospital ☐ Repatriated ☐

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

Medical Treatment Required at Final Destination:

Declaration by Physician

Date of this Medical Examination:

Charge for Examination: Payment Received: Yes ☐ No ☐

Full Name, Address and Telephone of Physician:

Physician's Signature

Physician's Stamp