



REPUBLIC OF CYPRUS
**MINISTRY OF
 COMMUNICATIONS AND WORKS**



**DEPARTMENT
 OF MERCHANT SHIPPING
 LEMESOS**

**MEDICAL REPORT FORM FOR SEAFARERS SERVING ON SHIPS UNDER
 THE FLAG OF CYPRUS**

For completion by ship's doctor or master and hospital or doctor ashore, in cases of illness or injury affecting seafarers.

Note: Copies of this form should be provided for the seafarers medical records, ship's master (or his representatives) and hospital/doctor ashore.

For completion by ship's master: Date: _____

Patient's Name: _____

Date of Birth _____ Name of ship: _____

Nationality _____ Shipowner: _____

Seafarers Name of ship's representative/agent
 Cyprus SB no: _____ on shore: _____

Shipboard Address and tel. no
 position held: _____ of ship's representative
 /agent on shore: _____

Details of illness or injury. Treatment received
 On board ship (enclose attachments if necessary) _____

Date of onset of illness: _____ Date injury occurred: _____

For completion by hospital or examining doctor on shore

Diagnosis: _____

(Full medical documentation should be attached, as necessary)

Details of specialized examinations: _____

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

Precautions to be taken on board ship: _____

Other observations of hospital or examining doctor: _____

	Yes	NO	When? _____
Should see another doctor?	<input type="checkbox"/>	<input type="checkbox"/>	Specify specialty: _____

Is the illness contagious or infectious?	<input type="checkbox"/>	<input type="checkbox"/>	Estimated duration of illness? _____
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Fit for normal work now?	<input type="checkbox"/>	<input type="checkbox"/>
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Fit for normal work from: _____ (indicate date)

Fit for restricted work	<input type="checkbox"/>	Specify: _____
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Unfit for work	<input type="checkbox"/>	For how many days? _____
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Bed rest necessary	<input type="checkbox"/>	For how many days? _____
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Recommended to be		YES	NO
- Repatriated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Air transport Recommended?	
		Should be accompanied?	

Name of Doctor (in capital letters written or stamped) _____
Position held _____
Address: _____ Tel. no _____

Place _____ Date _____

Signature of doctor _____