European Cruise Services Limited

You are required you to pass a Pre-Employment Medical Examination (PEME) prior to joining a cruise ship. This is to ensure you are fit to carry out both your routine and emergency duties. Please follow the instructions below to schedule a PEME appointment in a city near you and take a copy of this letter with you.

1) **All applicants must undergo a medical exam at a Company approved facility**.

2) Your appointment needs to be scheduled **at least 6 weeks prior** to your anticipated ship join date as it may take this duration to process the tests and complete the documentation. You must inform the clinic that you require an exam for the Company, your position, and your anticipated join date. You must take **one passport photo and a valid photo I.D**. with you to your appointment.

3) **You are responsible for the cost of your PEME** and may be reimbursed. Note that you will be charged for your medical examination regardless of whether you pass the medical examination or not. The examining facilities may require a deposit and a penalty fee may be charged for no shows or late cancellations.

4) **If you have any significant health problems and are concerned about your ability to pass the exam, please discuss these with the facility in advance of the examination.** Some specific medical conditions may result in denial or deferment of your conditional job offer. These include but are not limited to: cardiovascular disease, abnormal liver functions, epilepsy, insulin dependent diabetes, anxiety, mood, and eating disorders, and obesity. Obesity is defined as a Body Mass Index greater than 30. You are encouraged to calculate your own BMI prior to scheduling an exam by using the following equation, BMI = pounds/inches^2 or using the BMI calculator at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

5) The general examination includes a physical exam, urine test, blood draw, abdominal ultrasound and chest x-ray. If indicated, additional tests may be required. All repeated tests will not be reimbursed. A drug test may be require of you as well. It is important that you know the company will disqualify without further notice should you test positive for any type of drugs or abused substance.

6) You may also be required to undergo vaccinations. **Yellow Fever, Tetanus and MMR (Measles, Mumps, Rubella) shots will be needed if you did not receive the vaccination within the past 10 years. Not having the booster within the past 10 years will delay the process.** If you cannot prove you have had it, you need to get it. The PEME has a "Vaccine Administration Record" you and/or doctor must complete the form. While only Yellow Fever and Tetanus vaccinations are required, please document all other vaccinations and boosters you may have received.

7) If you are **declared FIT and pre-cleared to join by the Company**, you must bring all the PEME forms including the laboratory and diagnostic tests reports printouts and the original Medical Fitness Certificate with you to the ship. Do not place it in your luggage as you will run the risk of getting it lost. We suggest you keep these documents in your carry-on at all time. Please take all these forms with you when joining your ship as they will be reviewed by the ship's medical staff. The fitness certificate has a maximum validity of 2 years provided that there are no health concerns or provided you do not have a break in employment for more than 120 days.

8) If you are **declared UNFIT by the appointed doctor, a doctor of your choice or by the Company Pre-Clearance review process**, you will receive your self-declaration, examination findings, laboratory results but you will not be issued with a medical fitness certificate. Your assignment will be cancelled.

9) Remember, it is **your responsibility** to ensure that you take your original medical fitness certificate when joining a ship which must be valid for the length of your entire contact. If these requirements are not met, you may be immediately repatriated at your own expense. Paperwork can get lost. It is highly suggested that you have an electronic copy available at all times.

The PEME process is not a simple one, and sometimes it does get held up. But, if you take ownership of it and follow through, the process can move more smoothly. If you have any questions regarding the process, please contact your hiring agent.

Revised: December 13, 2015

European Cruise Services Limited

List of Signatory Countries

Bahamas Maritime Authority (BMA), Standards of Training, Certification and Watchkeeping (STCW), Maritime Labor Convention (MLC) signatory countries approved doctors.

Algeria	Antigua & Barbuda	Argentina	Australia	Azerbaijan
Bahamas (The)	Bangladesh	Barbados	Belgium	Belize
Benin	Bosnia and Herzegovina	Brazil	Brunei Darussalam	Bulgaria
Cambodia	Canada	Cape Verde	Chile	China (inc Hong Kong)
Colombia	Comoros	Cook Islands (The)	Cote d'Ivoire	Croatia
Cuba	Cyprus	Czech Republic	DP Republic of Korea	Denmark & Faroe Is
Dominica	Ecuador	Egypt	Eritrea	Estonia
Ethiopia	Fiji	Finland	France	Georgia
Germany	Ghana	Greece	Honduras	Hungary
Iceland	India	Indonesia	Iran (IRO)	Ireland
Italy	Israel	Jamaica	Japan	Jordan
Kenya	Kiribati	Kuwait	Latvia	Lebanon
Liberia	Lithuania	Luxembourg	Libyan Arab Jamahiriya (The)	Madagascar
Malaysia	Malawi	Maldives	Malta	Marshall Islands
Mauritania	Mauritius	Mexico	Micronesia (FSO)	Montenegro
Morocco	Mozambique	Myanmar	Netherlands (in Aruba, Curacao, St Maarten)	New Zealand
Nigeria	Norway	Oman	Pakistan	Palau
Panama	Papua New Guinea	Peru	Philippines	Poland
Portugal	Qatar	Republic of Korea	Romania	Russian Federation
Saint Kitts and Nevis	Saint Vincent and the Grenadines	Samoa	Saudi Arabia	Senegal
Serbia	Singapore	Slovak Republic	Slovenia	Solomon Islands
South Africa	Spain	Sri Lanka	Sweden	Switzerland
Syrian Arab Republic	Thailand	Togo	Tonga	Trinidad & Tobago
Tunisia	Turkey	Tuvalu	Ukraine	United Arab Emirates
United Kingdom Inc Bermuda	British Virgin Islands and Cayman Islands	Gibraltar and Isle of Man	United Republic of Tanzania	United States
Uruguay	Vanuatu	Venezuela (BRO)	Vietnam	

Revised: December 13, 2015

European Cruise Services Limited

PRE-EMPLOYMENT MEDICAL EXAMINATION
FORM “A”

Crewmember’s Name:______________________ Date of Birth:________________ Place of Birth______________________

Crew ID Number____________________ Position:_____________________Nationality:____________________ Sex: Male ☐ Female ☐

Type of Ship: Passenger Trade Area: Worldwide

SECTION A— SEAMAN'S PERSONAL MEDICAL HISTORY

Do you have or have you ever had any of the following conditions?
Mark each item “YES” or “NO”. Every item marked “YES” must be fully explained in “Section C”

Condition	Yes	No	Condition	Yes	No
1 Frequent Ear Infection?			43 Nervous Breakdowns?		
2 Hearing Problems?			44 Depressions and/or Anxiety?		
3 Glaucoma?			45 Any psychological disorder?		
4 Conjunctivitis?			46 Any Neurological disorder?		
5 Do you wear glasses or contact lenses?			47 Any psychiatric illness/disorder?		
6 Eye Injury and/or Eye problems?			48 Immunologic or lymphatic illness?		
7 Sinus Trouble?			49 Endocrine Disease or Illness? Including diabetes		
8 Frequent Nosebleeds?			50 Arthritis and/or numbness?		
9 Frequent Colds?			51 Blood in Urine?		
10 Swollen Lymph Nodes?			52 Kidney Stones and/or Cysts?		
11 Asthma and/or Wheezing?			53 Any type of renal disease?		
12 Bronchitis or Tuberculosis?			54 Any type of gallbladder disease?		
13 Pneumonia?			55 Gallbladder stones and/or polyps?		
14 Coughing up Blood?			56 Muscular Weaknesses?		
15 Shortness of Breath ?			57 Malaria or other tropical disease?		
16 Rheumatic Fever?			58 Hepatitis A, B, or C?		
17 High or Low blood pressures?			59 Cancer or tumors or Cysts?		
18 Chest Pain and/or Heart Attack?			60 Lupus?		
19 Irregular heart beat or Poor Circulation?			61 Varicose Veins?		
20 Stroke and/or Paralysis?			62 Bone or Joint Paint?		
21 Other heart disease?			63 Serious Accidents or Illness?		
22 Loss of Sensation or Tingling?			64 Thyroid disease or illness?		
23 Deformities?			65 Treated for an autoimmune disease?		
24 Abdominal Pains?			66 Undergoing dental treatment?		
25 Gastric or Duodenal Ulcers?			67 Do you have any illnesses today?		
26 Frequent Diarrheas or Constipation?			68 Any type of hernia and/or rupture?		
27 Indigestion?			69 Have you been hospitalized?		
28 Bleeding from Stomach or Bowels?			70 Have you received a blood transfusion?		
29 Hemorrhoids?			71 Have you had an operation?		
30 Jaundice or Liver Problems/Disease?			72 Have you been repatriated for any reason in the past?		
31 Urinary Track Infections?			73 Are you taking any type of medication (incl. vitamins)?		
32 Prostate disease- (Males only)?			74 Are you undergoing any type of medical treatment?		
33 Sexually Transmitted Diseases?			75 Have you been certified unfit for duty?		
34 Breast Mass and/or Breast Tenderness?			76 Do you drink alcoholic beverages? If yes, how much?		
35 Skin diseases? (e.g. dermatitis or eczema)?			77 Do you Smoke? If yes, then how much per day?		
36 Any type of Allergies?			78 Have you ever had an MRI?		
37 Any type of joint pain?			79 Have you ever had a CT Scan?		
38 Any Sprains and/or Bone Fractures?			**FEMALE CREWMEMBERS ONLY**		
39 Any type of Back Pain?			1 Have you had a pregnancy?		
40 Frequent Headaches?			2 Are you or do you think you are pregnant?		
41 Loss of Consciousness?			3 What was the date of your last menstrual period?		
42 Seizures and/or Epilepsy?			4 Have you ever had lumps, cysts or tumor in your breast?		

CAUTION: Failure to bring the original PEME with all laboratory and other reports may cause you to be denied boarding. Misrepresentations, false and/or erroneous information on this PEME application may result in the loss of benefits and termination of employment.

Revised: December 13, 2015

Crewmember's Name:_______________________________ Crewmember's ID:_ ________________

SECTION B— FAMILY MEDICAL HISTORY

Does any member of your family have or ever had the following medical conditions?
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in "Section C"

Condition	Yes	No	Condition	Yes	No
1 Heart condition / angina?			9 Any type of psychological disorders?		
2 Blood pressure problems?			10 Tuberculosis?		
3 Stroke / vascular disease?			11 Asthma and/or eczema?		
4 Nervous disorder?			12 Glaucoma?		
5 Diabetes?			13 Epilepsy, fits, nervous breakdown?		
6 Arthritis?			14 Cancer, tumors, cysts?		
7 Renal/Kidney Disease?			15 Any type of allergies?		
8 Immunologic and/or Lymphatic Disease /Illness?			16 Endocrine Disease or Illness?		

SECTION C— EXPLANATION OF QUESTIONS

PLEASE READ THE BELOW STATEMENT BEFORE SIGNING--- IMPORTANT INFORMATION

I hereby state that all statements and information provided in this application are true and correct to the best of my knowledge. I further acknowledge my understanding that reliance is to be given to the information contained herein for the purposes of obtaining employment. As such, I agree that my employment may be terminated immediately if it is found that the information contained herein is misrepresented, false, and/or erroneous and in such event, I hereby waive all benefits and rights under any employment contract, collective bargaining agreement (CBA), including but not limited to the POEA.

I consent to be tested for HIV, Aids Virus and any type of Sexually Transmitted Diseases. I consent to have the results revealed to my Employer, the shipowner, its agents and its affiliates.

Crewmember's Name ______________________________ **Physician's Name** ________________________

Crewmember's Signature___________________________ **Physician's Signature** ________________________

Date: _______/_______/_________ **Date:** _______/_______/_________

CAUTION: You may be denied boarding if you fail to bring the original PEME with all laboratory tests results and other reports. You will be responsible for the cost of room, board and repatriation should you be denied boarding.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS & INFORMATION

Re: Crewmember/Patient: ______________________________

Nationality: ______________________________________

Date of Birth: ____/______/_______

TO WHOM IT MAY CONCERN

This document authorizes all physicians, hospitals and all other medical attendants to furnish to my employer, the shipowner, its agents, the vessel, and/or affiliates a complete genuine copy of my medical records, bills and reports and any other medical information related to my treatment(s). I hereby appoint my employer, its affiliates, its agents, the shipowner and the medical personnel aboard my disembarking vessel to act as my representative in requesting all medical records and information, including but not limited to verbal conversations with any medical and/or health care provider.

ANY AND ALL records, including, but not limited to: applications for medical insurance, policies of medical insurance, statements of medical insurance benefits, all medical records, consultation records, diagnostic records, examination records, treatment records, physician notes, nurse notes, office memoranda, charts, all correspondence including emails, CT Scan films, records and reports, diagnostic test records and reports, EEG records and reports, EKG records and reports, lab records and reports, MRI films, records and reports, X-ray films, records and reports, and any and all bills, invoices, statements, or other documentation on amounts owed or paid (regardless of the source of payment) relating to the consultation, diagnosis, examination, and/or treatment of **the above-referenced crewmember.**

I am signing my name above the words “AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION” which is printed below and which is adopted by me as my own, to show that I mean everything that is said on this document.

By: ___________________________ (sign) Date:___________________________
Crewmember’s Signature

“AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION”

European Cruise Services Limited

PRE-EMPLOYMENT MEDICAL EXAMINATION-- FORM "D"

MEDICAL CERTIFICATE

To be completed by physician only

Crewmember's Name :_______________________________ Date of Birth: _______________ Examination Date: ________/______/_______

Place of Birth:___________________________ Sex: Male ☐ Female ☐

Nationality:__ ____________________________ Type of Ship: Passenger Trade Area: Worldwide

VITALS

Temp:	Pulse:	Resp:	B/P	Height:	Weight:

HEARING EXAM

Field Vision		
R= WNL ☐ or ______ L= WNL ☐ or ______	WNL ☐ or Other ______ **See Summary of Required Exams for details. X-ray report with clinical finding must be attached to this form.**	WNL ☐ or Other ______ **EKG report with clinical finding must be attached to this form.**

HZ	500	1000	2000	3000	4000	6000	8000
Right Ear							
Left Ear							

Any subjective signs of impaired hearing or dizziness? ____ Yes or ____ No. General Information concerning use of hearing protection provided? ___ Yes or ____ No

VISION EXAM **CHEST X-RAY** **ELECTROCARDIOGRAM (EKG)**

VACCINATIONS— you must attached copy vaccination booklet to this form in addition to completing the below.

PHYSICAL EXAMINATION

HEENT	Normal	Abnormal	THORAX	Normal	Abnormal	ABDOMEN	Normal	Abnormal	RECTAL	Normal	Abnormal
Mouth			Percussion			Shape			Hemorrhoids		
Tonsils			Auscultation			Tenderness			Prostate		
Pharynx			EXTREMITIES	Normal	Abnormal	Masses			Fistula		
Ears			Varicose Veins			Scars			PELVIC	Normal	Abnormal
Eyes			Edema			Hernias			NEURO		
NECK	Normal	Abnormal	Discoloration			Circumcised			Motor		
Nodes			Deformities			Testicles			Sensory		
Motion			Breast			HEART	Normal	Abnormal	Reflexes		
Thyroid			Scars			Rhythm			EMOTIONAL STATUS	Normal	Abnormal
						Murmurs					

RANGE OF MOTION TESTS

CERVICAL	Normal	Abnormal	SHOULDER	Normal	Abnormal	WRIST	Normal	Abnormal	LUMBAR	Normal	Abnormal
Fwd. Flex			Fwd elev.			Pronation			Fwd Flex		
Extension			Bwrd Elev.			Supination			Extension		
Lat. Flex			Abduction			Dorsiflexion			Lat. Flex		
Rotation			Adduction			Abduct			Rotation		
ELBOW	Normal	Abnormal	Int. Rotation			Adduct			SLR-Sitting		
Retain Flex			Ext. Rot.			Planer Flex					
Extension			KNEE	Normal	Abnormal	ANKLES	Normal	Abnormal	SLR--Supine		
Pronation			Retain Flex			Dorsal Flex					
Supination			Extension			Plantar Flex			FEET	Normal	Abnormal
FINGERS	Normal	Abnormal				Inversion			Inspection		
Flexion						Eversion			Arch Status		
Extension									Flat		

☐ **Fit for work: (the crewmember is not believed to be suffering from any sickness or physical or mental ailment making him unfit for service or which may endanger the health of the other persons onboard.)**

☐ **Unfit to work (Reason :_____________________________)** ☐ **Fit after defect corrected (Describe in separate document)**

Physician Name: __________________________ **Address:** ________________________________ **Country:** ___________________________

Physician's Signature:______________________ **Telephone Number:**_______________________ **Email:** ______________________________

PEME CERTIFICATE VALIDITY DATES

Pre-Employment Medical Examination certificate is valid for a maximum period of 2-years from the date noted on this Medical Certificate. This validity period may be reduced if there any health concerns or the Seafarer has been out of the Company's employment for 4 months (120-days) or greater time. The Company will not accept incomplete Medical Certificate or certificates that do not have a date. For more details, you can ask your hiring agent access so you can read the full PEME Certificate Validity Policy.

European Cruise Services Limited

PRE-EMPLOYMENT MEDICAL EXAMINATION-- FORM “E”

To be completed by physician only

Vaccine Administration Record

Patient's Name ______________________

Patient's Date of Birth ______________________

Patient's Nationality ______________________

This is a vaccination record card only. This document should be use to only record the vacciations that the patient has been adminstered.
This document IS NOT AN INSTRUCTION TO VACCINATE but to record. The only required vaccinations are: YELLOW FEVER, TETANUS AND MMR.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding source (F,S,P)[2]	[3] & Site[3]	Vaccine		Vaccine Information		Vaccinators (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Td, Tdap) Give IM.3									
Hepatitis A6, (e.g., HepA, HepA-HepB) Give IM.3									
Hepatitis B6, (e.g., HepB, HepA-HepB) Give IM.3									
Human papillomavirus, (HPV2, HPV4) Give IM.3									
Measles, Mumps, Rubella (MMR) Give SC.3									
Varicella (VAR) Give SC.3									
Pneumococcal, (e.g., PCV13, conjugate;									
Meningococcal, (e.g., MenACWY, conjugate; MPSV4, polysaccharide) Give MenACWY IM.3 Give MPSV4 SC.3									
Influenza, (e.g., IIV3, trivalent inactivated; IIV4, quadrivalent inac- tivated; RIV, recombinant inac- tivated; LAIV4, quadrivalent live attenuated) Give IIV and RIV IM.3 Give LAIV IN.3									
Hib Give IM.3									
Zoster (Zos) Give SC.3									
Yellow Fever									
Other									

How to Complete This Record

1. Ask the Patient about his vaccination history so you may complete the form. You should document all of the patient's vaccination on this form if the ifnormation is available. If the information is not available, then leave it blank. You ARE REQUIRE TO DOCUMENT THE YELLOW FEVER, TETANUS AND MMR VACCINATION
2. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine .
3. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
4. Record the route by which the vaccine was given as either intramuscu- lar (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
5. Record the publication date of each VIS as well as the date the VIS is given to the patient.
6. To meet the space constraints of this form and federal requirements for docu- mentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
7. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (sanofi pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac (sanofi pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4	Gardasil (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
PCV13, PPSV23	Prevnar 13 (Pfizer); Pneumovax 23 (Merck)
MenACWY	Menactra (sanofi pasteur); Menveo (Novartis)
MPSV4	Menomune (sanofi pasteur)

Abbreviation	Trade Name and Manufacturer
LAIV (Live attenuated influenza vaccine)	FluMist (MedImmune)
IIV (Inactivated influ- enza vaccine), RIV (recombinant influenza vaccine)	Afluria (CSL Biotherapies); Agriflu (Novartis); Fluarix (GSK); Flublok (Protein Sciences Corp.); Flucelvax (Novartis); FluLaval (GSK); Fluvirin (Novartis); Fluzone, Fluzone Intradermal, Fluzone High-Dose (sanofi pasteur)
Hib	ActHIB (sanofi pasteur); Hiberix (GSK); PedvaxHib (Merck)
ZOS (shingles)	Zostavax (Merck)

European Cruise Services Limited

PRE-EMPLOYMENT MEDICAL EXAMINATION-- FORM “F”

To be completed by physician only

Standard 5-Panel Drug Test

Drug Group	EIA Screen Cutoff Level* (ng/mL**)	GC/MS Confirmation (ng/mL**)	Results Positive or Negative
Amphetamines (amphetamine and methamphetamine)	1,000	500	
Cocaine metabolite	300	150	
Marijuana metabolites	50	15	
Opiates (codeine and morphine)	2,000	2,000	
Phencyclidine	25	25	

* These are standard cutoff levels; alternate cutoff levels may be available.

** Nanograms per milliliter; the above cutoff levels, list of analytes and test methodologies are subject to change when required by applicable government regulations or guidelines.

Crewmember’s Name ______________________________________
Crewmember’s ID No.:_____________________________________
Crewmember’s Nationality: ________________________________
Crewmember’s Place of Birth: ______________________________
Date of Medical Certificate issued ___________________________

Name of Medical Practitioner issuing the Medical Certificate
____
and the name Physician certifies to the best of his knowledge after examining the patient and reviewing the laboratory tests that he is satisfied the name crewmember is free of disease, defect or condition which precludes or is likely to lead to problems during a voyage .

European Cruise Services Limited

PRE-EMPLOYMENT MEDICAL EXAMINATION-- FORM "G"

SUMMARY OF ALL REQUIRED EXAMS

YOU MUST ATTACH THE ACTUAL LABORATORY TESTS' REPORTS TO THIS SUMMARY

To be completed by physician only

BLOOD CHEMISTRY	Normal	Abnormal
Glucose		
Blood Urea Nitrogen (BUN)		
Creatinine		
Total Bilirubin		
Alanine aminotransferase (ALT) or SGPT		
aspartate aminotransferase (AST) or SGOT		
Total Cholesterol		
Triglyceride		
Uric Acid		

COMPLETE BLOOD COUNT (CBC)	Normal	Abnormal
Leucocytes (WBC)		
Erythrocytes (RBC)		
Hemoglobin		
Hematocrit		
Mean Corpuscular Volume (MCV)		
Mean Corpuscular Hemoglobin (MCH)		
neutrophils		
lymphocytes		
monocytes,		
eosinophils,		
basophils		
platelet count		

URINANALYSIS	Normal	Abnormal
Color		
Appearance		
PH		
Nitrites		
Glucose		
Ketones		
Protein		
Urobilin		
Leucocytes (WBC)		
Erythrocytes (RBC)		
Epithelial Cells		
Crystals		
Bacteria		

Crewmember's Name ______________________________
Crewmember's ID No.:______________________________
Crewmember's Nationality: ___________________________
Crewmember's Place of Birth: _________________________
Date of Medical Certificate issued ______________________

Name of Medical Practitioner issuing the Medical Certificate

____

and the name Physician certifies to the best of his knowledge after examining the patient and reviewing the laboratory tests that he is satisfied the name crewmember is free of disease, defect or condition which precludes or is likely to lead to problems during a voyage .

Revised: December 13, 2015

CHEST X-RAY		
Circle the test result. If patient has any indication of TB, enlarge heart, Atherosclerotic Aorta, and/or vascular disease, then Patient shall be declared unfit.		
Bony Cage	Negative	Positive
Heart	Negative	Positive
Lungs	Negative	Positive
Diaphragms	Negative	Positive

ULTRASOUND		
Circle the test result. If patient has kidney and/or gallbladder disease, then Patient shall be declared unfit.		
Abdominal	Normal	Abnormal

STOOL TESTS		
Circle the test result. If result is positive, then Patient shall be declared unfit.		
Parasites	Negative	Positive
Culture	Negative	Positive

FEMALE CREWMEMBERS ONLY		
Circle the test result. If result is positive, then Patient shall be declared unfit.		
Pregnancy	Negative	Positive
Circle the test result. If PAP Smear result is class III or greater, then Patient shall be declared unfit		
PAP Smear	Class I	Class II

HEPATITIS PROFILE		
Circle the test result. If result is positive, then Patient shall be declared unfit.		
Hepatitis A (IgM)	Negative	Positive
Hepatitis B Surface Antigen	Negative	Positive
Anti-hepatitis C (RIBA)	Negative	Positive

OTHER TESTS		
Circle the test result. If result is positive, then Patient shall be declared unfit.		
HIV	Negative	Positive
VDRL OR RPR (Syphilis)	Negative	Positive

ELECTROCARDIOGRAM (EKG)		
This test shall be done to all crew age 40 or greater or crew with a history of cardiac problems including hypertension. Please circle the test result. If patient has a history of MI, then Patient shall be declared unfit.		
EKG	Normal	Abnormal

PROSTATE SPECIFIC ANTIGEN (PSA)		
This test shall be done to all crew age 50 or greater or crew with a history of prostate problems. Please circle the test result. PSA level 4 ng/mL or under is consider "normal." PSA level higher than 4 ng/mL, then the Patient shall be declared unfit.		
PSA	Normal	Abnormal