

**SELF DECLARATION HEALTH STATUS REPORT
(Revalidation Pre-Employment Medical Form)**

POSITION: SHIP:		DATE: NEW HIRE: Yes No			
First name:		Last Name:		Sex:	Date of Birth:
ID Number:		Place of Birth:		Nationality:	
HAVE YOU EVER HAD, OR DO YOU NOW HAVE ANY OF THE FOLLOWING:					
CONDITION		Yes	No	CONDITION	
1. Epilepsy/Seizures/Fainting/Severe Headaches				11. Low Back Pain/Back Injury	
2. Heart Disease/High or Low Blood Pressure				12. Arthritis/Rheumatism	
3. TB/Asthma/Hay Fever/Allergies/Lung Disease				13. Bone or Joint Injury/Knee Injury/Varicose Veins	
4. Stomach Illness/Ulcer				14. Abnormal Blood Studies/Cancer/Abnormal Pap Test	
5. Hepatitis/Liver Disease/Kidney Disease				15. Psychiatric illness/Counseling/therapy	
6. Diabetes/Thyroid Disease				16. Vision or Hearing problems of any type	
7. Prostate/Hernia/Other Urologic Condition				17. Hospitalization/Surgical Operation	
8. Syphilis/Gonorrhea/Sexually Transmitted Disease				18. Serious Injury/Serious Illness/Accidents of any type	
9. Flu/Influenza/Diarrhea/GI problems.				19. Any type of pain	
10. Received Medical Treatment aboard any Cruise ship				20. Ship's doctor sent you a shore side doctor for any type of treatment	
HAVE YOU EVER RECEIVED ANY OF THE FOLLOWING:			HAVE YOU EVER BEEN:		
21. Compensation for Job Injury or illness				23. Refused Employment for Physical Reasons	
22. Disability benefits				24. Repatriated for medical reasons	
ARE YOU CURRENTLY:					
21. Under a doctor's care?				22. Taking medicines?	
23. Have you taken any medications/injections over the past 48 months?					
IF ANY OF THE ABOVE ANSWERS IS "YES" YOU MUST EXPLAIN BELOW:					

I AFFIRM THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST TO MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT FALSIFICATION IS GROUNDS FOR TERMINATION WITHOUT BENEFITS. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION CONCERNING MY PAST, PRESENT OR FUTURE MEDICAL CONDITIONS, BY ANY PRACTITIONER OR HOSPITAL, TO MY EMPLOYER OR ITS THIRD PARTY ADMINISTRATOR OR THEIR REPRESENTATIVES.

I AM ABLE TO READ, WRITE AND SPEAK ENGLISH, AND I FULLY UNDERSTAND THE ABOVE QUESTIONS.

I confirm to the best of his knowledge that I am free of disease, defect or condition which precludes or is likely to lead to problems during my employment contract aboard any vessel.

Crewmember's Signature (Required): _____

Crewmember's Name _____

Crewmember's ID No.: _____

Crewmember's Nationality: _____

Crewmember's Place of Birth: _____

Date of Original Medical Certificate issued _____

DRUG FREE WORKPLACE ACKNOWLEDGMENT

As an employee, I hereby acknowledge that I am aware a copy of the policy regarding the maintenance of a drug free workplace is house within the vessel's Safety Management System (SMS).

I, however, have been informed that the unlawful manufacture, distribution, dispensation, possession and/or use of a controlled substance (to include but not limited to such drugs as marijuana, heroin, cocaine, PCP, and crack, and other drugs known or unknown at the time this form is issued and that may also include legal drugs which may be prescribed by a licensed physician if they are abused), is prohibited.

I acknowledge that I must report for work in a fit condition to perform my duties. Violation of the Company's policies makes me subject to discipline up to and including termination of employment, which may also compel me to bear the cost of my repatriation and to pay the cost of my replacement to come to work aboard the vessel due to my breach of contract resulting from use or possession of prohibited substances.

As a condition of employment, I must abide by the terms and conditions of employment aboard a vessel. I realize that law may mandate the employer to communicate my use or possession of prohibited substances to the appropriate government agencies under certain circumstances.

In accordance with the drug free workplace, I certify that as a condition of my employment, I do not currently use illegal drugs.

I read and understand the above information. Therefore, I am signing my name below and adopt this document as my own, to show that I am in agreement with everything that is said in this document.

Employee Signature: _____

Employee ID Number: _____

Date: _____

PATIENT RESPONSIBILITIES ACKNOWLEDGMENT

Health is ultimately the responsibility of the individual. It is absolutely necessary for you to take personal responsibility for health to harness the full benefits of health and healing. You have to realize that nobody owns your state of health, and nobody has a larger stake in it, like you do. Lifestyle plays a major role in most of the illnesses. Given the well-documented relationship between lifestyle, disease burden and healthcare costs, it makes economic and medical sense to hold individuals morally responsible for their health-related choices. Hence, you are responsible for your health, maintaining good health and

- To ensure preventive actions to avoid getting physically and mentally sick and/or injured at all stages of your life.
- To present accurate identifying information. This includes information about all aspects of your health status, conditions, any medications, including over the counter products and dietary supplements, and any allergies or sensitivities.
- To present details of illnesses or complaints in a direct and straightforward manner.
- To cooperate responsibly with all persons involved in the health care process.
- To keep appointments on time.
- To cancel appointments only when absolutely necessary, and far enough in advance so that other patients might utilize that time.
- To pay for all services rendered according for any charges not paid for by your employer or a health insurance company or a third party (known or unknown at the time this document is issued).
- To comply with the treatment plan provided by the health professional, including but not limited to the ship's medical officers and staff.
- To ask for clarification whenever information or instructions are not understood.
- To provide both positive and negative feedback to the health professional responsibly for care.
- Be respectful of all health care professionals and staff, as well as other patients.

I read and understand the above information. Therefore, I am signing my name below and adopt this document as my own, to show that I am in agreement with everything that is said in this document.

Employee Signature: _____

Employee ID Number: _____

Date: _____

RELEASE OF LIABILITIES FOR FAILURE TO FOLLOW SAFETY PROCEDURES, LACK OF DILIGENCE FOR MAINTAINING GOOD HEALTH PRACTICES, AND FOR ALL PRE-EXISTING CONDITIONS

I understand my employment may be physically and emotionally demanding and that certain risks and dangers exist. I, however, agree that I can control my decisions and agree to follow all safety guidelines and procedures for working aboard a vessel.

I state that I am not now under the influence of any chemical substance, including alcohol, and that I will not be under the influence of any substance when living and/or working aboard the vessel. I realize that being under the influence of a substance may endanger myself and others.

I understand and assume all dangers and risks (both known and unknown) of injury, illnesses and/or disability associated with my employment and waive, release, and discharge my employer, the shipowner and vessel's operator and its agents, officers, and employees from all claims or causes of action arising from my lack of diligence for my health and safety, failure to follow safe procedures in performing my duties, lack of diligence in taking care of my own health and participating in any unsafe activity while living and working aboard a vessel.

I do hereby release my employer, shipowner and operator and their agents, officers, and employees from any and all liability, and agree to indemnify and hold my employer, shipowner and operator harmless for any accidents, injury, loss or damage of property, and from any legal fees that I may ever have as a direct or indirect result of participating in the unsafe activities, failure to follow safety procedures, lack of diligence for my own health, any illness or injury resulting from a pre-existing condition (whether disclosed or undisclosed at any time during my employment). This release, indemnification, and waiver shall be construed broadly to the maximum extent under applicable law. By signing below I am agreeing that I have carefully read and understand to all of the sections above.

I read and understand the above information. Therefore, I am signing my name below and adopt this document as my own, to show that I am in agreement with everything that is said in this document.

Employee Signature: _____

Employee ID Number: _____

Date: _____