	Patriot Crew Data Form Form HR-145	Page 1 of 3

Document #: 45HR145	Date: 20 FEB 2014	Approved By: Port Captain	PCS Revision #: 5

General Instructions

<u>This form shall be completed by the crewmember</u> <u>prior to joining a vessel</u>. <u>Once completed, this form is to be faxed or emailed to the PCS Crewing Department by the dispatching union</u>. <u>The union is also to provide a copy of the completed form to the crewmember so they may submit it to the Captain (OIC while in ROS) when signing onto the vessel.</u> *Crewmembers should also retain copies for their records. This form is intended to be filled out either by hand, or electronically, if so desired.*

A copy will be retained onboard ship for 1 year. A copy will be retained by the PCS Crewing Department for 5 years**.**

<u>Each section of this form must be fully completed. Incomplete forms or sections will be returned.</u>

<u>It is the responsibility of the Mariner to complete and resubmit this form to the PCS Crewing Department when any of the below listed information changes.</u>

Full Last Name:	*Full First Name:*	*Full Middle Name: (NMN if no middle name)*
Social Security Number:	*Merchant Mariner Document (MMD) Number:*	*MMD Exp. Date:*
Street Address:	*City and State:*	*Zip Code:*
Day time Telephone Number:	*Cell Phone / Pager Number:*	*Email:*
Birthplace City, State, Country:	*Birth Date:*	*Citizenship:*

Desired Airport:	*TWIC Expiration Date:*

Passport Number:	*Passport Issue Date:*	*Passport Expiration Date:*

Complexion:	*Eye Color:*	*Hair Color:*	*Weight:*	*Height:*	*Sex:*

Drivers License Number:	*State of Issuance*

Next of Kin Last Name:	*Next Of Kin First Name:*	*Relationship:*
Next of Kin Street Address:	*Next of Kin City, State and Zip Code:*	*Next of Kin Day Time Phone Number:*

401k Deduction: (IF APPLCIABLE BY CONTRACT)	*Overtime Conversion to Vacation: (IF APPLCIABLE BY CONTRACT)*
	☐ *None* ☐ *Some (# of hours)* ☐ *All*

Patriot Contract Services, LLC

MSC PHYSICAL REQUEST

All below listed sections must be completed and returned prior to physical approval. Anderson & Kelley (Patriot's third party medical provider) will contact you directly for scheduling.

Name (first, Middle, last):

Today's Date:

Social Security Number (last 4 only): ***-**-

Union: **Port of Dispatch:**

Vessel:

Expected Reporting Date (Month/Day):

City∈ 3ïéð (Location physical will be scheduled)**:**

Preferred Date of Physical (Month/day/year):

Contact Number (below):

- Primary: Type:
- Secondary: Type:

E-MAIL Address:

Last Tuberculosis Screening (below):

Date: Results: Never Screened/Unknown:

Frequency of MSC Physicals (COMSCINST 6000.1D):

Up to age 39:	Once
Ages 40-49:	Every 5 years
Age 50-59:	Every 2 years
Age 60 and over:	Annually

Employee's Withholding Allowance Certificate (W4)

Print your full name: **Last:** **First:** **Middle:**	**Your Social Security Number:**
Address including Zip Code:	**Birth Date:**
Marital Status ☐ Single ☐ Married **Note:** if married but legally separated, or spouse is nonresident alien, check single	
1. Total number of allowances you are claiming	
2. Additional amount, if any you want deducted from pay check (if your employer agrees)	
3. I claim exemption from withholding because (see instructions and check boxes below that apply): a. Last year I did not owe any Federal Income Tax and had the right to a full refund of ALL income tax withheld, and b. This year I do not expect to owe any Federal Income Tax and expect to have a right to full refund of ALL income and tax withheld. If both a and b apply enter EXEMPT here → c. If you entered "EXEMPT" on line 3b, are you a full time student?	☐ YES ☐ NO ☐
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or if claiming Exemption from withholding, that I am entitled to claim the exempt status.	
Employee's Signature: Date:	

Section 1- DIRECT DEPOSIT

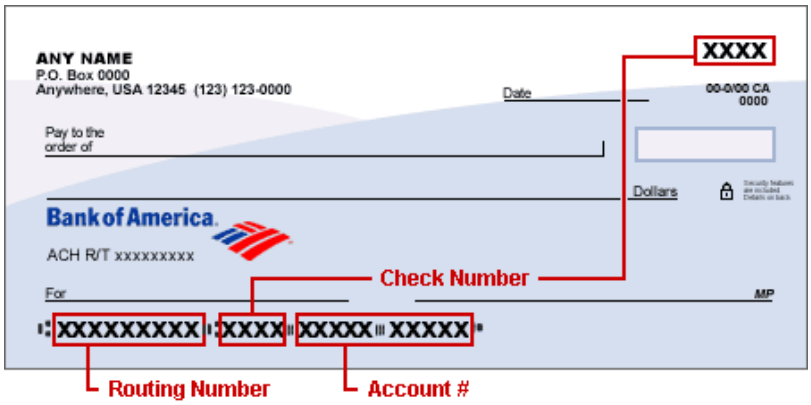
You must have an active checking or savings account for Direct deposit. If you choose Direct Deposit (electronic bank transfer) you must complete the following and include a copy of a voided check. Funds will not be available for transfer up to two (2) pay period.

Section 2 – MANUAL (LIVE) CHECK

If you did not elect Direct deposit and if not otherwise indicated below, checks will be sent to your home address.

SECTION 1

Name (Last):	***First :***	***Middle:***
Bank Name:	***Routing number (bank number):***	***Account #***



If you are unable to provide a copy of a voided check you must sign below verifying that the account information listed in section one (1) is accurate and that Patriot Contract Services, LLC will not be responsible for lost funds deposited incorrectly due to inaccurate information provided by you.
Crewmember Signature_____ Date_____

SECTION 2

I WILL NOT BE ELECTING DIRECT DEPOSIT AND REQUEST MY PAYROLL CHECK is SENT TO…
(if no option is selected your check will automatically be sent to your home address)

MY HOME ADDRESS PROVIDED ON MY W-4 FORM

THE VESSEL I AM CURRENTLY ASSIGNED

PATRIOT CONTRACT SERVICES, LLC

SEAMAN'S DECLARATION OF HEALTH AND MEDICAL AUTHORIZATION

(Pre-sign on, after selection of the job from the Union Hall)

I, _____ **, present myself for employment aboard the vessel,**
(print your name)

_____ **and state that I am physically, mentally and**
(name of vessel)

professionally fit to perform my assigned duties as _____
(state your rating)

PLEASE ANSWER THE FOLLOWING:

NOTE: FAILURE TO ANSWER ALL QUESTIONS COMPLETELY AND TRUTHFULLY, OR WILLFULLY CONCEALING ANY PHYSICAL OR MENTAL CONDITION WHICH AFFECTS YOUR ABILITY TO PERFORM YOUR DUTIES, MAY RESULT IN YOUR MAINTENANCE AND CURE BENEFITS BEING DENIED AND/OR TERMINATION OF EMPLOYMENT.

Have you received medical treatment and/or had surgery within the last two years? Yes No

If yes, please provide the following information.

1. **Nature of illness or injury:** _____
2. **Name and address of doctor, hospital and medical facility:**
   _____
3. **Dates of treatment:** _____
4. **Date released from treatment:** _____

Check below if you now have, or ever have had, the following: ***(Explain any "YES" answers on the back of this form.)***

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Alcoholism/Drug Dep			Are you now pregnant?			Arthritis		
Asthma			Back ache/back injury			Blood in urine or stool		
Broken or fractured bones			Cancer			Coronary illness		
Chronic or migraine headache			Diabetes			Dizziness or fainting		
Epilepsy			Head injury			Heart trouble		
Hepatitis			Hernia			High blood pressure		
Kidney disease			Liver Disease			Lung/Respiratory Illness		
Malaria			Mental/nervous disorder			Neck ache/neck injury		
Psychiatric treatment			Rheumatism			Stomach illness		
Tuberculosis (PPD)			Ulcer			Venereal disease		
PPD Test Date:	Results:							

Any other injury or illness not listed above: _____

Are you presently taking any medications? Yes No

If yes, please identify the medications, dosage and frequency you are taking:

_____

Do you have sufficient medication to complete the voyage? Yes No

Do you have any allergies to food, medication, latex, etc? Yes No

If yes, identify all allergies: _____

CERTIFICATION AND AUTHORIZATION

In the event I become ill or injured, this form will serve as a MEDICAL AUTHORIZATION for American Ship Management to obtain past, present and future medical records concerning my treatment, from any physician or medical facility.
I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT AND THAT MY SIGNATURE HERETO RELEASES THE MEDICAL INFORMATION AS AUTHORIZED ABOVE.

Signature: _____ **Date:** _____

VESSEL OFFICER REVIEW

International Certificate of Vaccination Received by Vessel Officer **Date:**____/____/____

Other Documents Required:

Unlicensed	Date	Licensed	Date
Clinic card valid through	____/____/____	CG drug clearance (attach)	____/____/____
Date of last exam	____/____/____	Permanent: Annual exam	____/____/____
CG drug clearance (attach)	____/____/____	Rotary: Pre-sign on exam	____/____/____
		Attach Fit for Duty Slip	____/____/____

Signature reviewing vessel officer: _____ **Date:** _____

Distribution: Original to ASM Claims; copy to be retained on board the vessel.