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 Cyprus SB no: _______________ Name of ship's representative/agent on shore: __________________________________

Shipboard position held: ________________ Address and tel. no 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	
Should see another doctor?	☐	☐	When? __________________________ Specify specialty: _________________
Is the illness contagious or infectious?	☐	☐	Estimated duration of illness? _________________________
Fit for normal work now?	☐	☐	

Fit for normal work from: ____ (indicate date)

Fit for restricted work	☐	Specify: ___________________________
Unfit for work	☐	For how many days? _______________
Bed rest necessary	☐	For how many days? _______________

Recommended to be

- Repatriated ☐
- Hospitalized ☐

	YES	NO
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 ___________________________