Carnival

January 2007

Dear Doctor for **New Hires,** and **Returning Crew,**

Prior to employment with Carnival Cruise Lines all **New Hire** applicants are required to successfully complete a valid physical exam. Previously employed Carnival crewmembers who have not worked for Carnival for a period exceeding 6 months are considered **New Hire** applicants. A renewal physical is required every two years for crew continuing employment without any breaks in service **(Returning Crew)**. The first two pages are the Employee History forms that the crewmember must fill out completely, giving a detailed history of their past and present medical history. The last two pages are the Physical Examination forms to be completed by the examining physician.

Must have proof of MMR vaccination

The following tests are to be included as part of that bi-annual exam. Copies of the lab reports and x-ray studies are to be attached to the physical exam form.

CBC:	Complete blood count
Metabolic panel to include:	Glucose, Calcium Potassium, Sodium BUN (Blood Urea Nitrogen), Creatinine Alanine Aminotransferase (SGPT or ALT) Aspartate Aminotransferase (SGOT or AST) Bilirubin
Hepatitis Screening:	Test for active Hepatitis B & C infection – if positive for Hep B, proceed with identification of chronic and/or carrier states
HIV:	Human Immunodeficiency Virus – if positive please repeat to rule out false positive.
Urine Dip Stick	Microscopic urinalysis only if dipstick positive
Urine Drug Screen	Please test for Amphetamines, Cocaine, Opiates, Phencyclidine, and THC
Chest X-Ray	Except for US, UK and Canadian residents
Electrocardiogram	For all male employees 40 years and older and all females 45 years and older
Females:	Urine pregnancy test if exam is greater than 28 days since last menstrual period
Males:	PSA for all male employees 50 years and older
All Crew 50 and over	Hemoccult for Blood

Please complete each form fully:

- Mark each of the exam findings as "normal" or "abnormal" and document on any abnormal results
- Explain fully all yes answers entered by crewmember and physician
- Sign and stamp the medical forms.

An incomplete form may result in the crewmember not beginning/returning to work as scheduled.

All New Hire Applicants: please forward copies of the physical form and all related notes and reports to the Crew Medical Department **(fax 305-406-6540 or newhirephysicals@carnival.com)**

Returning Crew: please **only submit** completed physicals **if/when abnormal results and/or significant medical problems are identified that require additional testing or further stabilization.**

All Crew must carry to the vessel the completed physical, laboratory results, radiology reports & proof of MMR

Sincerely,
Shipboard Personnel

CARNIVAL CRUISE LINES, CARNIVAL PLACE, 3655 NW 87 AVENUE, MIAMI, FLORIDA 33178-2428
EXECUTIVE OFFICES: (305) 599-2600

Carnival

New Hire ☐
Returning ☐
Rehire ☐

Employee History

To be completed by all new hires and returning crewmembers.

Name: _____ Date of Birth: _____ Nationality: _____

Position: _____ Crew #_____ Department: _____ Date of Hire: _____

Address: _____ Home Telephone #: _____

HAVE YOU HAD, BEEN TREATED FOR, AND/OR NEED FOLLOW-UP FOR ANY OF THE PROBLEMS LISTED BELOW. PLEASE MARK ALL OF THE ONES THAT APPLY TO YOU AND ADD COMMENTS BELOW.

- ❑ Eye problems
- ❑ Glasses / contacts
- ❑ Headaches / migraines
- ❑ Dizziness / fainting spells
- ❑ Seizures / Epilepsy
- ❑ Ear Infections
- ❑ Hearing loss
- ❑ Hearing aid(s)
- ❑ Nose bleeds
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Shortness of breath
- ❑ Allergies
- ❑ Hay Fever
- ❑ Skin problems / rashes
- ❑ High blood pressure
- ❑ Heart problems
- ❑ Chest pain
- ❑ Heart attacks or stroke
- ❑ Diabetes: Type I / II
- ❑ Thyroid problems
- ❑ Stomach pains
- ❑ Ulcers
- ❑ Acid reflux
- ❑ Chronic vomiting / diarrhea
- ❑ Gallbladder
- ❑ Arthritis
- ❑ Dislocated or broken bones
- ❑ Amputations / prosthetics
- ❑ Neck: pain / injury / surgery
- ❑ Shoulder: pain/ injury / surgery
- ❑ Back: pain / injury / surgery
- ❑ Hip / Leg: pain / injury / surgery
- ❑ Knee: pain / injury / surgery
- ❑ Varicose Veins: Surgery: Y / N
- ❑ Swelling to arms or legs
- ❑ Hernias of any kind
- ❑ Mental or nervous disorders
- ❑ Anxiety / Depression
- ❑ Sleeping disorders
- ❑ Eating disorders
- ❑ Alcohol or Drug abuse
- ❑ Benign tumors
- ❑ Breast lumps / masses
- ❑ Cancer Type:_____
- ❑ Anemia / blood disorders
- ❑ Menstrual problems
- ❑ Hepatitis: B / C
- ❑ Kidney stones
- ❑ Urinary infections
- ❑ Genital herpes
- ❑ HIV
- ❑ Syphilis / Gonorrhea
- ❑ Venereal warts
- ❑ Prostate problems
- ❑ Hemorrhoids
- ❑ Rectal bleeding

Please give a short history for any of the boxes you checked: _____

_____

_____

_____

_____

_____

I have read the lists above and marked all that apply. **Signature**:

Do you have any allergies? Y☐ N ☐

List allergies: _____

Do you smoke? Y☐ N ☐ If yes, # of cigarettes a day: _____

Do you drink alcohol? Y☐ N ☐ # of drinks a day: _____ week: _____

Have you ever been in the hospital? Y☐ N ☐

If yes: why & when? _____

_____

_____

_____

What operations have you had and when?

_____

_____

What medications do you take on a routine basis?

_____

_____

_____

Will you need these medications while on board? Y☐ N☐

For Females Only:

Date of last Pap? _____ Mammogram? _____

Do you have problems with your menstrual cycle? Y☐ N☐

Date of your last period? _____

Are you on birth control? Y ☐ N ☐

Circle type used: IUD / Pill / Injections / Other _____

Are you currently pregnant? Y ☐ N ☐

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Employee History

To be completed by all new hires and returning crewmembers.

Name: _____ Crew # _____ Date of Birth: _____

Have you ever been refused a job or military service due to a medical condition, illness or injury? Y ☐ N ☐

Have you ever been discharged from a job or military due to a medical condition, illness or injury? Y ☐ N ☐

Have you ever been given any money for a job related illness or injury? Y ☐ N ☐

What was the injury or illness? _____ When did it happen? _____

Have you worked for Carnival Cruise Lines in the past? Y ☐ N ☐

When? _____

Have you worked for any other cruise line before? Y ☐ N ☐

Name of cruise line and dates of employment? _____

Please provide us with a description of any medical problems you have had in the past that were not addressed on these pages below:

_____

_____

_____

_____

_____

_____

Proof of MMR Vaccination must be attached to the physical and carried by the crewmember

_____

_____

_____

_____

_____

The answers on my Employee Physical History forms including all representations concerning my prior medical history are true and correct to the best of my knowledge and belief. I understand that Carnival Cruise Lines will rely on these medical forms in determining whether I am eligible for employment. I also understand that falsification of these records is grounds for termination and may constitute grounds for denial of maintenance and cure benefits in the event that I become ill or injured. I authorize release of any medical information concerning my past, present, or future medical condition by any practitioner or hospital to Carnival Cruise Lines and its accredited representatives.

_____ _____

Applicant/Crewmember Signature Date

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Employee Physical Examination

To be completed by the examining physician: Please circle and check all that apply.

Name: _____ Crew # _____ Date of Birth _____

Height: _____ Weight: _____ Vital Signs: Temp: _____ Pulse: _____ Resp: _____ BP: L _____ R _____

Eyes			Breath Sounds			Gastrointestinal			Labs / Tests		Check if Completed
L: 20/ Corrected	20/		Clear & equal	No	Yes	Hx: Ulcers	Yes	No	**BMI = (Body Mass Index)**		
R: 20/ Corrected	20/		Wheezing / Rhonci	Yes	No	Acid Reflux	Yes	No	BMI = [weight / (height x height)] x 703		
Color Blindness	Yes	No	Tuberculosis	Yes	No	Abdominal Pains	Yes	No	**EKG** - Females 45+		
Red / Green			Chest X-ray	Abn	Nor	Nausea / Vomiting	Yes	No	**EKG** - Males 40+		
Yellow / Blue			**Skin**			Diarrhea	Yes	No	**ALL CREW over 50 Rectal exam**		
Other:			Warm / Dry / Intact	No	Yes	Constipation	Yes	No	Hemoccult for blood	Positive	Negative
Pterygium R / L	Yes	No	Lesions	Yes	No	Bowel sounds	Neg	Pos	**Males 50 and over**		
Glaucoma	Yes	No	Scars	Yes	No	Hemorrhoids present	Yes	No	PSA	Positive	Negative
Cataracts	Yes	No	Birthmarks	Yes	No	Hernias palpated	Yes	No	**REQUIRED FOR ALL CREW**		Check if Completed
Abnormal Vascularity	Yes	No	Jaundice	Yes	No	Hepatomegaly	Yes	No	Glucose		
Conjunctivitis	Yes	No	Discolorations	Yes	No	**Genitourinary**			CBC		
Exophthalmia	Yes	No	Eczema/Psoriasis	Yes	No	Hx: Kidney stones	Yes	No	Calcium		
Retinopathy	Yes	No	Ganglion cyst	Yes	No	Recurrent UTI's	Yes	No	Sodium		
Ears			Lymphomas	Yes	No	Urinary frequency	Yes	No	Potassium		
Active: Otitis media	Yes	No	Tattoos	Yes	No	Pain on urination	Yes	No	BUN (blood urea nitrogen)		
Otitis externa	Yes	No	**Cardiovascular**			Hematuria / Nocturia	Yes	No	Creatinine		
Ruptured Membrane	Yes	No	Hx:Heart disease	Yes	No	Venereal warts	Yes	No	SGOT/ALT		
Tumors / Masses	Yes	No	Palpitations	Yes	No	**Musculoskeletal**			SGPT/ALT		
Hearing loss	Yes	No	Chest Pain / MI	Yes	No	Osteo arthritis	Yes	No	Bilirubin		
Whisper Test	Abn	Nor	Pacemaker / IACD	Yes	No	Rheumatoid arthritis	Yes	No	Hepatitis B		
Nose			Arrhythmia's	Yes	No	Joint pains	Yes	No	Hepatitis C		
Septal: Deviation	Yes	No	Hypertension	Yes	No	Gout	Yes	No	HIV		
Nasal polyps	Yes	No	Congestive Failure	Yes	No	Muscle: weakness	Yes	No	Urinalysis		
Hx. Epistaxis	Yes	No	Cardiomegaly	Yes	No	Cramps	Yes	No	**Urinalysis to include:**		**Results**
Nasal fractures	Yes	No	Cardiomyopathy	Yes	No	Stiffness	Yes	No	Bilirubin		
Heavy snoring	Yes	No	Dyspnea on exertion	Yes	No	Deformities	Yes	No	Urobilinogen		
Tonsillitis	Yes	No	Pedal edema	Yes	No	Deviations	Yes	No	Acetone		
Dental			Varicose Veins	Yes	No	Injury/Pain/Surgery of:			Glucose		
Good hygiene	No	Yes	Homan's Sign	Pos	Neg	Back / Neck	Yes	No	Protein		
Cavities	Yes	No	**Males**			Shoulder/Arm/Wrist	Yes	No	Blood		
Gingivitis	Yes	No	Epididymitis	Yes	No	Knee / Leg /Ankle	Yes	No	Nitrite		
Mouth sores	Yes	No	Orchitis	Yes	No	**Neuro**			Leukocytes		
Respiratory			Hypo / Hyperspadias	Yes	No	Cranial Nerves 1 - 12	Abn	Nor	pH		
Hx: Asthma	Yes	No	Varicocele	Yes	No	Peripheral nerves	Abn	Nor	Specific gravity		
Bronchitis	Yes	No	Scrotal Hernia	Yes	No	Hx: Tremors / Seizure	Yes	No	**Urine drug screen To include:**		Attach Results
Emphysema	Yes	No	Prostatomegaly	Yes	No	Vertigo / Ataxia	Yes	No	Amphetamines		
Pneumonia	Yes	No	**Females**			Shunts	Yes	No	Cocaine		
Constant cough	Yes	No	Amenorrhea	Yes	No	**Emotional**			Opiates		
Sputum production	Yes	No	Dysmenorrhea	Yes	No	Hx: Insomnia	Yes	No	Phencyclidine		
Endocrine			Menorrhagia	Yes	No	Depression	Yes	No	THC		
Diabetes (Type I / II)	Yes	No	Menopause	Yes	No	Anxiety	Yes	No	**F&B handlers only**		
Polyuria / Polydipsia	Yes	No	Vaginal Discharge	Yes	No	Hallucinations	Yes	No	Stool: Salmonella	Positive	Negative
Thyroid problems	Yes	No	Breast exam: Lumps	Pos	Neg	Eating disorders	Yes	No	Shigella	Positive	Negative
									Ova/Parasites	Positive	Negative

Rev 01/2007 Date of exam: _____ Doctor Initials _____

Carnival

Employee Physical Examination

To be completed by the examining physician

Name: _____ Crew # _____ Date of Birth: _____

Please document and comment on all abnormal test results and physical findings in the space provided below.

A copy of all the applicant's lab results must accompany these completed medical forms. Please document on general appearance and mental attitude as needed. Please print clearly.

Last date of menstrual period: _____ If it has been greater than 28 days since the last menstrual period please do pregnancy test and attach result. If urine pregnancy dipstick test performed in the office please circle result: positive / negative.

Proof of MMR Vaccination must be attached to the physical and carried by the crewmember

I certify that I have examined the above named applicant according to the medical standards provided by Carnival Cruise Lines and can attest this applicant has completed all required tests and with a full physical examination, I have identified no reportable deficiencies, other than those listed above.

Printed name of examining physician: _____ Signature: _____

Address of examining physician: _____

Telephone: _____ Date of exam: _____

Applicant Name: _____ Stamp: