



**Employment Medical Examining Form A
NEW HIRES AND RETURNING CREWMEMBERS
PERSONAL DECLARATION**

Name: _____ Male: _____ Female: _____ Date of Birth: _____

Position: _____ Ship: _____ ID#: _____ Nationality: _____

DO YOU HAVE OR DID YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? ALL YES RESPONSES REQUIRE COMMENTS FROM THE EXAMINING PHYSICIAN IN ENGLISH

Condition:	Yes	No	Condition:	Yes	No
1. Frequent Ear Infections?			34. Prostate Disease (males)		
2. Hearing Problem / Hearing Aids			35. Hernias of any kind		
3. Glaucoma			36. Siphillis / HIV / Gonorrhea		
4. Conjunctivitis			37. Breast Mass / Lumps / Tenderness		
5. Do you wear glasses/contact lenses			38. Skin Problems / Rashes		
6. Eye injury/Eye Problems			39. Allergies / Anaphylaxis / to Environment, Chemicals, Food or Drugs		
7. Frequent Colds/Sinus Trouble			40. Hand or Wrist Pain/Problem?		
8. Al/Mononucleosis/ ChickenPox/Measles/Mumps			41. Joint Pains/Arthritis/ Numbness in Extremities?		
9. Nosebleed			42. Sprains / Dislocations / Fractures		
10. Frequent Sore Throat			43. Neck Pain / Scolios / Cervical Injury		
11. Swollen Glands			44. Back pain / Injury / Sciatica		
12. Asthma or Wheezing			45. Amputations/Prosthetics		
12. Bronchitis			46. Headaches / Dizziness / Loss of Consciousness / Migraines		
14. Tuberculosis (TB)			47. Head Injury or Concussion?		
15. Pneumonia			48. Seizures / Epilepsy / Receiving Medications for it		
16. Coughing up Blood			49. Nervous Breakdown / Depression / Anxiety / Psych. Cond.		
17. Shortness of Breath			50. Muscular Weakness		
18. Rheumatic Fever			51. Yellow Fever / Scarlet Fever / Malaria / Tropical Diseases		
19. Hepatitis / A___ B___ C___			52. Cancer or tumors		
20. High Blood Pressure			53. Serious Accidents / Illness		
21. Chest Pain			54. Thyroid Disease		
22. Heart Attack / Angina / Irregular Heart Beat			55. Have you ever been Hospitalized ? For What?		
23. Poor Circulation / Varicose Veins			56. Have you had ANY type of surgery ?		
24. Other Heart Disease			57. Have you ever received a blood transfusion? Why?		
25. Stroke			58. Are you taking any medications? What?		
26. Abdominal Pain			59. Alternative Medicine or Treatment? What?		
27. Gastritis / Reflux / Gastric or Duodenal Ulcer			60. Do you drink alcohol? How much per day: _____ week: _____		
28. Frequent Diarrhea or Constipation			61. Do you smoke? How much per day? _____		
29. Bleeding from Stomach or Bowels			62. Any other medical conditions, not listed above		
30. Jaundice / Gallbladder / Liver Problems			FEMALES:		
31. Diabetes / Type I___ II___			63. Are you or do you think you may be pregnant?		
32. Hemorrhoids / Rectal Bleeding			62. What was the date of your last menstrual period? _____		
33. Urinary Infection / Blood in Urine/Kidney Stones			63. Gynecological / Female Problems		

Comments: To be completed by physician

Question #	

Medical Consent/Authorization/Release

My signature below acknowledges that all statements provided by me in this application are true and correct to the best of my knowledge and belief, and I further authorize and consent to the release of any/all of my medical records from any source, including nations insurance offices, doctors, hospitals, and/or other institutions or public authorities. This general medical release will also authorize the release of any/all of my psychological or psychiatric records or referrals. I understand that falsification will be grounds for loss of benefits and/or termination of employment. My signature further acknowledges my consent to any/all physical examinations and diagnostic testing:

Employee Signature: _____ Date: _____ Physician Signature: _____

Reviewed by: _____ Title: _____ Physician Name (Print)

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3 SIGNED XEROX COPIES – 1. Hiring Partner 's File, 1. Hiring Partner (To send to RCCL/CCI Human Resources), 1.