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 ___________________________