Merchant Mariner Physical Examination Report

OMB 1625-0040
Expires 07/31/2009

Section I – Applicant Information

Name (Last, First, Middle) of Applicant

Date of Birth (Month, Day, Year) | Social Security Number

Section II - Physical Information

Eye Color	Hair Color	Weight ________lbs	Distinguishing Marks
Height ______ft ______in	Blood Pressure Systolic _______ / Diastolic _______		Pulse Resting ________ ☐ Regular ☐ Irregular

Section III - Vision (if you have corrected vision, BOTH uncorrected & corrected MUST be shown)

UNCORRECTED	CORRECTABLE TO	FIELD OF VISION
Right 20 / ____________	Right 20 / ____________	☐ Normal
Left 20 / ____________	Left 20 / ____________	☐ Abnormal

The applicant must have **100** degrees horizontal field of vision

Section IV – Color Vision

☐ PASS ☒ FAIL

Deck Officers/Ratings (masters, mates, pilots, operators, able-seaman) must be tested using one of the following tests. For all other licenses/ratings, see page 1, note 3.

Pseudoisochromatic Plates

0 ☐ Divorine - 2nd Edition
1 ☐ AOC
2 ☐ AOC Revised Edition
3 ☐ AOC - HRR
4 ☐ Ishihara 16, 24, 38 Plate Edition
5 ☐ Eldridge - Green Perception Lantern
6 ☐ Farnsworth Lantern (FALANT)
7 ☐ Keystone Orthoscope
8 ☐ Keystone Telebinocular
9 ☐ SAMCTT- School of Aviation Medicine
10 ☐ Titmus Optical Vision Test
11 ☐ Williams Lantern

Section V - Hearing

☐ **NORMAL** ☐ **IMPAIRED (If impaired, complete Audiometer and Functional Speech Discrimination Test)**

Audiometer (Threshold Value)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Right Ear (Unaided)				
Left Ear (Unaided)				
Right Ear (Aided)				
Left Ear (Aided)				

Functional Speech Discrimination Test at 55 dB

Right Ear (Unaided) __________% **Left Ear (Unaided)** __________%

Right Ear (Aided) __________% **Left Ear (Aided)** __________%

Section VI - Medications

List all current medications, including dosage and possible side effects.
State the condition(s) for which the medication(s) are taken.

☐ **NO PRESCRIPTION MEDICATIONS**

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Section VII – Certification of Physical Impairment or Medical Conditions

Does the applicant have or ever suffered from any of the following?
<u>If YES, PROVIDE TEST RESULTS, AS INDICATED.</u>

If YES:
- **Identify the condition**
- **Any limitations**
- **Is condition controlled**
- **Date of diagnosis**
- **Prognosis**

	Yes	No		Remarks (Please Print)
			1. Circulatory System	
0			a. Heart disease **(Stress Test within the past year)**	
1			b. Hypertension **(Recent BP reading)**	
2			c. Chronic renal failure	
3			d. Cardiac surgery **(Stress Test within the past year)**	
4			e. Blood disorder/vascular disease	
			2. Digestive System	
5			a. Severe digestive disorder	
			3. Endocrine System	
6			a. Thyroid dysfunction **(TSH level within the past year)**	
7			b. Diabetes **(State effects on vision & HgbAlc w/in 30 days)**	
			4. Infectious	
8			a. Communicable disease	
9			b. Hepatitis A, B or C	
10			c. HIV	
11			d. Tuberculosis	
			5. Mental System	
12			a. Psychiatric disorder	
13			b. Depression	
14			c. Attempted suicide	
15			d. Alcohol abuse	
16			e. Drug abuse	
17			f. Loss of memory	
			6. Musculoskeletal System	
18			a. Amputations	
19			b. Impaired range of motion	
20			c. Impaired balance/coordination	
			7. Nervous System	
21			a. Epilepsy/seizure	
22			b. Dizziness/unconsciousness	
23			c. Paralysis	
			8. Respiratory System	
24			a. Asthma **(PFT results within the past year)**	
25			b. Lung disease **(PFT results within the past year)**	
			9. Other	
26			a. Debilitating allergies	
27			b. Other eye disease **(Corrected/Uncorrected Visual acuity)**	
28			c. Glaucoma **(Pressure test results within the past year)**	
29			d. Recent or repetitive surgery	
30			e. Sleepwalking	
31			f. Severe speech impediment	
32			g. Other illness or disability not listed	

Considering the findings in this examination, and noting the physical demands that may be placed upon the applicant, I consider the applicant **(please check one)**

☐ **Competent** ☐ **Not competent** ☐ **Needing further review**

Name of Physician/Physician Assistant/Nurse Practitioner	License Number	Telephone Number	Office Address, City, State, Zip

Signature of Physician/Physician Assistant/Nurse Practitioner	**Date**

I certify that all information provided by me is complete and true to the best of my knowledge

X **Signature of <u>Applicant</u>** **Date**