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? _____

		YES	**NO**
Recommended to be		Air transport Recommended?	☐ ☐
- Repatriated	☐		
- Hospitalized	☐	Should be accompanied?	☐ ☐

Name of Doctor (in capital letters written or stamped) _____
Position held _____
Address: _____ Tel. no _____

Place ______________________________________ Date _______________________________

Signature of doctor ___________________________