OMB No. 1625-0040
Expires: mm/dd/20xx

APPLICATION FOR MEDICAL CERTIFICATE (FORM CG-719K)

------ Instructions ------

Who must submit this form?

1. Applicants seeking a medical certificate are required to complete this form and submit all pages, including instructions, to the U.S. Coast Guard (Coast Guard). Guidance for completion of this form can be found in the Merchant Mariner Medical Manual, COMDTINST M16721.48, at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF.
2. Mariners applying for or holding a merchant mariner credential (MMC) **with only an entry-level endorsement** who serve on a vessel not subject to the International Convention on Standards of Training, Certification and Watchkeeping (STCW) but who request **a medical certificate that satisfies the Maritime Labor Convention (MLC), AND want to be qualified for lookout duties** should submit this form. Sections III (Medical Conditions), IV (Medications) and V (Physical Examination) of the CG 719K **DO NOT** have to be completed. The medical certificate will be restricted to entry-level only.
3. The Coast Guard will not accept an application for a medical certificate without a mariner reference number or a Social Security number.

Who may conduct this exam?

1. All exams, tests and demonstrations must be performed, witnessed or reviewed by a physician, physician assistant, or nurse practitioner licensed by a state in the United States (U.S.), a U.S. possession, or a U.S. territory.
2. Medical examinations for United Sates Registered Pilots must be conducted by a licensed medical doctor.

Special Requirements for Applicants Under the Age of 18

If the applicant is under 18 years of age, the application must include a statement, signed by a parent or legal guardian, that includes the following:

1. Applicant's name;
2. Applicant's Social Security number or mariner reference number;
3. A statement giving the Coast Guard permission to issue a medical certificate to the applicant; and
4. Full printed name and signature of the parent or legal guardian (please specify relationship to the applicant).

All Applicants

1. Provide your name and date of birth on each page of the form where requested.
2. Before submitting, review the form to ensure that all sections have been filled out completely.
3. Remember to sign the Applicant Certification in Section X on page 8 of this form.

General Instructions for the Medical Practitioner

1. Complete all portions of the form marked "To be completed by the Medical Practitioner." Incomplete forms will cause delays and may adversely affect the applicant's ability to work.
2. Review all information provided by the applicant or others on this form. Initial and date each page of this application in the area designated to acknowledge that you have reviewed the information provided and to ensure form integrity.
3. Review the medical evaluation guidance contained in the Merchant Mariner Medical Manual, which can be found here: https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF
4. Understand that any illness, condition, or medication that has the potential to cause sudden incapacitation, altered sensorium, or loss of awareness could render the mariner unable to perform their duties or respond appropriately in an emergency situation. Such an occurrence places the vessel at risk of an accident and poses a danger to the mariner, other crewmembers, the public, and maritime safety.
5. Consider that In the event of a medical emergency, immediate medical response may be limited to the vessel's crew, and outside help may be delayed.

PRIVACY ACT STATEMENT

Pursuant to 5 U.S.C. §552a(e)(3), this Privacy Act Statement serves to inform you of why DHS is requesting the information on this form.
AUTHORITY: 14 U.S.C. § 505; 46 U.S.C. §§ 2103, 7101, 7302, 7502; 46 C.F.R. 10.301
PURPOSE: To determine whether an applicant meets the regulatory standards for issuance of a U.S. Merchant Mariner Credential (MMC). The U.S. Coast Guard (USCG) evaluates an applicant's qualifications to determine compliance with the national and international requirements for issuance of the MMC, any endorsement within the MMC, and medical certificate.
ROUTINE USES: The information is used by authorized USCG personnel who have a need for the record to determine whether an applicant is a safe and suitable person and qualifies for the MMC, any endorsement within the MMC, and medical certificate. In addition, the USCG uses the information to maintain and update records of merchant mariner document transactions. This information will not be shared outside of DHS except in accordance with the provisions of DHS/USCG-030, Merchant Seamen's Records, 74 Federal Register 30308 (June 25, 2009).
CONSEQUENCES OF FAILURE TO PROVIDE INFORMATION: Furnishing this information (including your SSN) is voluntary. However, failure to furnish the requested information may result in the non-issuance of the medical certificate.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The United States Coast Guard estimates that the average burden for this form is 18 minutes. You may submit any comments concerning the accuracy of this burden or any suggestions for reducing the burden to the Chief, Office of Merchant Mariner Credentialing, 2703 Martin Luther King, Jr. Ave, S.E., STOP 7509, Washington, D.C., 20593-7509.

MEDICAL PRACTITIONER INITIALS: _______ **DATE OF EXAM:** _______________

Print Applicant Name: *(Last, First, MI.)* [ ] Date of Birth: *(MM/DD/YYYY)* [ ]

Section I: Applicant Information - To be completed by the Applicant and reviewed by the Medical Practitioner

1. Legal Name

Last	First	Middle	Suffix (Jr., Sr., III)	Alias(es) or Maiden Name(s) (if applicable)

2. Provide one: ☐ Mariner Reference Number OR ☐ Social Security Number (SSN) (ONLY if you do not have an MRN)

3. Sex: Female ☐ Male ☐

4. Date of Birth (MM/DD/YYYY)

5. Contact Information - Please indicate the best method(s) of contact by checking the appropriate box(es) below.

5a. Home Address (Principal place of residence. P.O. Box is NOT acceptable) ☐

Street Address

City State Zip Code

5b. Mailing Address - (P.O. Box is acceptable) Please provide the address where you want all correspondence sent. If mailing address is left blank, correspondence will be sent to the Home Address. ☐

Street Address

City State Zip Code

5d. Primary Phone Number (Required)

5e. Alternate Phone Number (optional)

5f. E-mail Address - (Optional) If provided, the National Maritime Center may attempt to contact you via e-mail. You will receive automated updates regarding the status of your application.

5g. Please provide additional means of communicating with you (satellite phone, work phone, etc.) (optional).

5c. Indicate address where you would like medical certificate mailed.

Home Address ☐ Mailing Address ☐ Other Address ☐

Specify Other Address Here:

Section II: Food Handler Certification - To be completed by the Medical Practitioner

1. Food Handlers must obtain a statement from the **Medical Practitioner** that attests that they are free of communicable diseases that pose a direct threat to the health or safety of other individuals in the workplace. For applicants seeking Food Handler Certification, the **Medical Practitioner** may provide the attestation by answering Yes or No to the question in bold below.
2. **Communicable disease** is defined in 46 CFR 10.107(b) as any disease capable of being transmitted from one person to another directly, by contact with excreta or other discharges from the body; or indirectly, via substances or inanimate objects contaminated with excreta or other discharges from an infected person.
3. The **Medical Practitioner** need not perform any additional testing unless it is deemed clinically necessary. Applicants and currently employed food workers should report information about their health as it relates to **diseases that are transmissible through food**. Circumstances that the **Medical Practitioner** should consider when certifying an applicant include, but are not limited to, the following:
   a. Whether the applicant reports they have been diagnosed with, or exposed to an illness due to organisms including, but not limited to, Salmonella Typhi, Shigella Spp., Shiga-toxin-producing Escherichia coli, or Hepatitis A virus within the past month.
   b. Whether the applicant reports they have at least one symptom caused by illness, infection, or other source that is associated with an acute gastrointestinal illness such as diarrhea, fever, vomiting, jaundice, or sore throat with fever.
   c. Whether the applicant reports they have a lesion containing pus, such as a boil or infected wound, which is open or draining and is on hands or wrists or on exposed portions of the arms.

Is the applicant free from communicable disease? *Yes* ☐ *No* ☐

MEDICAL PRACTITIONER INITIALS: _______ **DATE OF EXAM:** _______________

Print Applicant Name: *(Last, First, MI.)* Date of Birth: *(MM/DD/YYYY)*

Section III(a): Medical Conditions - To be completed by the Applicant and reviewed by the Medical Practitioner

Applicants must report their relevant medical conditions to the best of their knowledge. Applicants should check YES if: 1) they have had a previous diagnosis, or treatment for the condition by a health care provider; 2) they are currently under treatment or observation for the condition; or 3) the condition is present, regardless of treatment status. For any conditions marked YES, the applicant should circle or list the condition, and the medical practitioner should discuss the condition in Section III(b).

To the best of your knowledge, have you ever had, or do you presently have any of the following conditions?

ITEM	YES	NO	CONDITIONS
1.	☐	☐	1. Poor night vision, eye disease or injury, eye surgery, abnormal color vision, cataracts or glaucoma
2.	☐	☐	2. Hearing loss, hearing aid, ear surgery, facial deformities, open tracheostomy or frequent severe nose bleeds
3.	☐	☐	3. High or low blood pressure
4.	☐	☐	4. Heart or vascular disease of any kind, to include angina, chest pain, irregular heart beat, heart valve problem/replacement, heart attack/ myocardial infarction, or congestive heart failure
5.	☐	☐	5. Heart surgery and/or implanted devices (for example, angioplasty, stent, pacemaker, or defibrillator)
6.	☐	☐	6. Lung disease of any type (for example, asthma, emphysema, or chronic obstructive pulmonary disease (COPD))
7.	☐	☐	7. Any blood disorder (for example, anemia, hemophilia, blood clots, or polycythemia)
8.	☐	☐	8. Diabetes, glucose intolerance, or sugar in urine
9.	☐	☐	9. Thyroid problem requiring treatment or hospitalization
10.	☐	☐	10. Stomach, liver or intestinal disorder requiring ongoing medical care/medication, or causing significant bleeding or debilitating pain; history of hepatitis or jaundice
11.	☐	☐	11. Kidney problems/stones or blood in urine
12.	☐	☐	12. Any other urinary or bladder problems not listed above requiring treatment or hospitalization
13.	☐	☐	13. Skin disorders requiring medical treatment, such as cancer, tumors, scleroderma or lupus
14.	☐	☐	14. Severe allergies or allergic reactions to any substance, medication, food, or insect stings
15.	☐	☐	15. Communicable disease or chronic infectious diseases such as tuberculosis, HIV/AIDS, or hepatitis
16.	☐	☐	16. Any sleep problems (for example, obstructive sleep apnea, restless leg syndrome, narcolepsy, shift work sleep disorder, or insomnia)
17.	☐	☐	17. Epilepsy, fits, or seizures
18.	☐	☐	18. History of serious head injury, loss of consciousness or memory loss
19.	☐	☐	19. Frequent or severe headaches
20.	☐	☐	20. Dizziness/fainting spells/balance problems
21.	☐	☐	21. Frequent motion sickness requiring medication
22.	☐	☐	22. Stroke or Transient Ischemic Attack (TIA), brain tumor or other brain disorder
23.	☐	☐	23. Any neurologic disorder or nerve problems including numbness and/or paralysis, not listed above
24.	☐	☐	24. Attention deficit disorder with or without hyperactivity
25.	☐	☐	25. Anxiety, depression, bipolar disorder, adjustment disorder, post traumatic stress disorder (PTSD), or schizophrenia
26.	☐	☐	26. Suicide attempt or thought(s) of suicide (Suicidal Ideation)
27.	☐	☐	27. Evaluation, treatment, or hospitalization for alcohol or substance use, abuse, addiction, or dependence including illegal drugs, prescription medications, or other substances
28.	☐	☐	28. Any other psychiatric disorder, mental health evaluation/treatment/hospitalization
29.	☐	☐	29. Back, neck or joint problems that impair movement or cause debilitating pain
30.	☐	☐	30. Amputation, prosthesis, or use of ambulatory devices (for example, cane, walker, or braces)
31.	☐	☐	31. Injuries, fractures or recurrent dislocations that cause impairment or limit motion of your joint(s)
32.	☐	☐	32. Have you ever been signed off or repatriated from a vessel for medical reasons within the last six years?
33.	☐	☐	33. Any diseases, surgeries, cancers, illnesses, or disabilities not listed on this form?
34.	☐	☐	34. Any hospital admissions within the last six years not listed elsewhere in this section?

MEDICAL PRACTITIONER INITIALS: ______ **DATE OF EXAM:** ______________

Print Applicant Name: *(Last, First, MI.)* ____________ Date of Birth: *(MM/DD/YYYY)* ____________

Section III(b): Medical Conditions - To be completed by the Medical Practitioner

Instructions: For each item marked **YES** in Section III(a), the **Medical Practitioner** must provide the information requested IN THE BLOCKS below.
Please **attach appropriate evaluation data** for conditions that are subject to further review. Information on conditions that are subject to further review and the recommended evaluation data can be found in the Merchant Mariner Medical Manual, located at
https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF
Additional rows may be added by Applicant and/or Medical Practitioner. Use the "+" button to add more rows or "-" button to remove specific rows.

+	Item #	Date of onset diagnosis (mm/dd/yyyy)	Condition	Treatment	Status	Limitations
-						
-						
-						
-						
-						
-						

MEDICAL PRACTITIONER INITIALS: _______ **DATE OF EXAM:** _______________

Print Applicant Name: *(Last, First, MI.)* ______________ Date of Birth: *(MM/DD/YYYY)* ______________

Section IV: Medications - To be completed by the Applicant and reviewed by the Medical Practitioner

Do you currently use any medication (prescription or nonprescription)? Yes☐ No☐ **If YES,** provide the information requested in the blocks below.

Applicants Must Report

1. All prescription medications that were filled or taken within 30 days prior to the date that the applicant signs the CG-719K; and
2. All medications (Prescription or Nonprescription), dietary supplements, and vitamins that were used for a period of 30 or more days within the last 90 days prior to the date the applicant signs the CG-719K.

Medical Practitioner

1. Medical Practitioner must verify applicant's medications and information listed in the table below.
2. Medical Practitioner comments should include the approximate length of time the applicant has taken the medication and address the presence or absence of any side effects.
3. Verification of medications includes questioning the applicant about any medications or other substances reported, reviewing relevant medical conditions to determine if the applicant has omitted any medications or other substances, and affirmatively reporting any omitted current medications or other substances where required.

Additional guidance on medications, including those that may be considered disqualifying, can be found in the Merchant Mariner Medical Manual, located at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF.

Additional rows may be added by Applicant and/or Medical Practitioner. Use the "+" button to add more rows or "-" button to remove specific rows.

+	MEDICATION	DOSE	FREQUENCY	CONDITION	MEDICAL PRACTITIONER COMMENTS *(Duration of Use/Side Effects)*
-					
-					
-					
-					
-					
-					

REPORT OF MEDICAL EXAMINATION

Section V: Physical Examination - Items 1-16 must be performed and completed by the Medical Practitioner.

Height *(feet and inches):*		**Weight** *(pounds):*		**Pulse Resting:**		**Blood Pressure:**		**Body Mass Index** *(BMI):(For BMI > 40 refer to Section VIII)*	

Please make comments in the space provided on any item indicated as an "abnormal" system/organ.

Item	Normal	Abnormal	Item	Normal	Abnormal	Item	Normal	Abnormal
1. Head, Face, Neck, Scalp	☐	☐	7. Upper/Lower Extremities	☐	☐	13. Skin	☐	☐
2. Eyes/Pupils/EOM	☐	☐	8. Spine/Musculoskeletal	☐	☐	14. Neurologic	☐	☐
3. Mouth and Throat	☐	☐	9. Vascular System	☐	☐	15. Mental Status	☐	☐
4. Ears/Drums	☐	☐	10. Abdomen	☐	☐		**No**	**Yes**
5. Lungs and Chest	☐	☐	11. General/Systemic	☐	☐	16. Hernia	☐	☐
6. Heart	☐	☐	12. Extremities/Digits	☐	☐			

Additional Medical Comments (Please Print)

MEDICAL PRACTITIONER INITIALS: _______ **DATE OF EXAM:** ______________

Print Applicant Name:*(Last, First, MI.)* ______ Date of Birth: *(MM/DD/YYYY)* ______

Section VI: Vision - Must be performed by the Medical Practitioner, their medical staff or other qualified practitioners. Results must be reviewed by the **Medical Practitioner**.

a. Visual Acuity

1. Distance Vision, Uncorrected (Required for all applicants)

Right: 20/ ☐

Left: 20/ ☐

2. Distance Vision Corrected (if applicant requires corrective lenses)

Right: 20/ ☐

Left: 20/ ☐

3. Field of Vision

☐ Normal (the applicant's horizontal field of vision is greater than or equal to 90 degrees).

☐ Abnormal

b. Color Vision: The applicant must demonstrate satisfactory color vision sense using one of the testing methodologies listed below, **without the use of color enhancing lenses**. The Medical Practitioner must indicate which test was utilized, and the number of errors obtained.

1. Color Vision Test Administered:

☐ AOC (1965) - (6 or fewer errors on plates 1-15)

☐ AOC-HRR (2nd Edition) - (No errors in test plates 7-11)

☐ HRR PIP (4th Edition) - (No errors in test plates 5-10)

☐ Richmond (2nd and 4th Edition) - (6 or fewer errors)

☐ Titmus Vision Tester/OPTEC 2000 - (No errors on 6 plates)

☐ OPTEC 900 (colored lights) Test per instruction booklet

☐ Ishihara pseudoisochromatic plates test, 14 plate (5 or less errors)

☐ Ishihara pseudoisochromatic plates test, 24 plate (6 or less errors)

☐ Ishihara pseudoisochromatic plates test, 38 plate (8 or less errors)

☐ Farnsworth Lantern (colored lights) Test per instruction booklet

☐ Dvorine (2nd Edition) pseudoisochromatic 15 plate test (6 or less errors)

2. Color Vision Testing Results: ☐ Passed ☐ Failed Number of Errors: ☐

3. Alternative Testing: The medical practitioner should complete this section for applicants who are unable to pass one of the tests listed above and/or who are requesting consideration to demonstrate their color vision sense by an alternative test. Indicate the alternative test that you are submitting for consideration AND submit a copy of the test and evaluation results with the medical certificate application.

Name of alternative test administered: ____________________

Section VII: Hearing - Must be performed by the **Medical Practitioner**, their medical staff or other qualified practitioner. Results must be reviewed by the **Medical Practitioner**.

An applicant with normal hearing by forced whispered voice at ≥ 5 feet with or without hearing aids DOES NOT need to complete either the audiometer test or the functional speech discrimination test.

1. Does the applicant wear hearing aids? ☐ Yes ☐ No

2. Does the applicant have normal hearing by forced whisper voice at ≥ 5 ft, with or without hearing aids? ☐ Yes ☐ No

3. If the applicant's hearing is abnormal or causes concerns for maritime safety,, then perform either a functional speech discrimination test at 65dB or an audiogram documenting thresholds and averages as indicated below. Both aided and unaided values should be recorded for applicants requiring hearing aids.

(a) All applicants with an unaided threshold > 30dB in the better ear should have functional speech discrimination testing performed at 65dB.

(b) Refer to the Merchant Mariner Medical Manual, which can be found at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF . for further guidance. Report any additional information or comments in Section IX.

Audiometer Threshold Value

	500Hz	1,000Hz	2,000Hz	3,000Hz	Average
Right Ear (Unaided)					
Left Ear (Unaided)					
Right Ear (Aided)					
Left Ear (Aided)					

Functional Speech Discrimination Test @ 65dB, if required by instruction (b) above

Right Ear (Unaided): ____ %

Left Ear (Unaided): ____ %

Right Ear (Aided): ____ %

Left Ear (Aided): ____ %

MEDICAL PRACTITIONER INITIALS: ______ **DATE OF EXAM:** ____________

Print Applicant Name:*(Last, First, MI.)* ____________ Date of Birth: *(MM/DD/YYYY)* ____________

Section VIII: Demonstration of Physical Ability - To be completed by the Medical Practitioner

LISTS OF TASKS CONSIDERED NECESSARY FOR PERFORMING ORDINARY AND EMERGENCY RESPONSE SHIPBOARD FUNCTIONS

SHIPBOARD TASK, FUNCTION, EVENT, OR CONDITION:	THE EXAMINER SHOULD BE SATISFIED THAT THE APPLICANT:
Routine movement on slippery, uneven and unstable surfaces.	Has normal agility and has no disturbance in sense of balance. Has no impairment or disease that prevents or limits any of the movements and physical activities listed in this table
Routine access between levels	Is able to climb up and down vertical ladders and stairways, without assistance.
Routine movement between spaces and compartments.	Is able to perform the following, without assistance: • step over a door sill or coaming 24 inches (61 centimeters) in height; • move through a rigid, restricted opening of 24 inches by 24 inches (61 by 61 centimeters); and • work in constricted spaces.
Open and close watertight doors (weighing up to 55 pounds or 25 kilograms), handcranking systems, and valve wheels.	Is able to perform the following, without assistance: • manipulate door closing systems; • extend both shoulders in forward direction; • rotate both shoulders; • rotate wrists to turn handles; and • reach above shoulder height.
Handle ship's stores.	Is able, without assistance, to lift a 40-pound (18.1 kilogram) load off the ground, and carry, push or pull the same load.
General vessel maintenance.	Is able to perform the following, without assistance: • crouch, kneel, crawl, stoop, and squat; • grasp, pinch, and demonstrate rapid alternating finger movements; • grip, lift and manipulate common tools; and • work with arms raised overhead.
Emergency response procedures including escape from smokefilled spaces.	Is able to perform the following, without assistance: • crouch, kneel and crawl; and • distinguish differences in texture and temperature by feel.
Stand a routine watch.	Is able to perform the following, without assistance: • intermittently stand on feet and/or walk for up to 4 hours with minimal rest periods; and • remain awake and mentally alert for a 4 – 6 hour shift.
React and respond to visual alarms, warnings, and instructions; emergency response procedures.	Fufills the eyesight standard for the merchant mariner credential(s) applied for. See Chapter 5 of the Merchant Mariner Medical Manual, COMDITINST M16721.48.
React to audible alarms, warnings, and instructions; emergency response procedures	Fufills the hearing standard for the merchant mariner credential(s) applied for. See Chapter 5 of the Merchant Mariner Medical Manual, COMDTINST M16721.48.
Participate in firefighting activities.	Is able to lift, drag and pull 40 pounds without assistance. Has no condition that is likely to impair their ability to safely tolerate wearing a respirator/breathing apparatus or other firefighting protective equipment.
Abandon ship.	Has the agility, strength and range of motion to put on a personal flotation device (PFD) or immersion suit, without assistance. Has full upper extremity range of motion and trunk rotation, and the ability to reach feet with both hands.

1. The **Medical Practitioner** should indicate whether the applicant can meet the guidelines listed in the table above. If the **Medical Practitioner** doubts the applicant's ability to meet the guidelines contained within this table, and for all applicants with a Body Mass Index (BMI) of 40 or higher, the **practitioner** should require that the applicant demonstrate the ability to meet the guidelines contained within this table. This does not mean, for example, that the applicant must actually don an exposure suit, pull an uncharged 1.5 inch diameter 50' fire hose with nozzle to full extension, or lift a charged 1.5 inch diameter fire hose to firefighting position. Rather, the **Medical Practitioner** may utilize alternative measures to satisfy themselves that the applicant possesses the ability to meet the guidelines in the second column. A description of the methods utilized by the **Medical Practitioner** should be reported in the **Comments** section provided below.
2. All practical demonstrations should be performed by the applicant without assistance. Any prosthesis normally worn by the applicant, and any other aid devices, may be used by the applicant in all practical demonstrations except when the use of such items would prevent the proper wearing of mandated personal protection equipment (PPE). Please, document use of any prosthesis or aid devices in the Comments section below.
3. If the **Medical Practitioner** is unable to conduct the practical demonstration, the applicant should be referred to a competent evaluator of physical ability. The Coast Guard recognizes that not all medical practitioners will have the equipment necessary to test all of the tasks as listed. Equivalent alternate testing methodologies may be used. For further information, see the Merchant Mariner Medical Manual, which can be found at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF .
4. If the applicant is unable to perform all of the functions listed in the table above, the **Medical Practitioner** should provide information on the degree or the severity of the applicant's inability to meet the standards. The results of any practical demonstration or attendant physical evaluation should be recorded in the **Comments** section provided below.

Physical Ability Results:

☐ Applicant **HAS** the physical strength, agility, and flexibility to perform all of the items listed in the physical ability table.

☐ Applicant **does NOT have** the physical strength, agility, and flexibility to perform all of the items listed in the physical ability table.

COMMENTS: *(Please Print)*

MEDICAL PRACTITIONER INITIALS: _______ **DATE OF EXAM:** ________________

Print Applicant Name: *(Last, First, MI.)* Date of Birth: *(MM/DD/YYYY)*

Section IX: Summary - To be completed by the Medical Practitioner

a. Applicant Proof of Identity: Applicants must present acceptable proof of identity to the Medical Practitioner conducting examinations. Proof of identity shall consist of one current form of valid government-issued photo identification. Examples of acceptable proof of identity include unexpired official identification issued by a Federal, State, or local government or by a territory or possession of the United States, such as a passport, U.S. driver's license, U.S. military ID card, Merchant Mariner Credential, or Transportation Worker Identification Credential.

Applicant proof of identity provided: Yes ☐ No ☐

b. Assessment:

1. Based on your evaluation and preliminary screening, is the applicant likely free of conditions that pose significant risk of sudden incapacitation or debilitating complication, to include uncontrolled obstructive sleep apnea, diabetes mellitus or coronary artery disease?

Yes ☐ No ☐ Applicant needs further evaluation by a medical professional ☐

2. To the best of your knowledge, is the applicant free from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board?

Yes ☐ No ☐ Applicant needs further evaluation by a medical professional ☐

3. If you checked **NO** or **Applicant Needs Further Evaluation for Questions 1 and/or 2, above**, please list the condition(s) of concern and explain the additional evaluation that you have recommended to the applicant (for example, applicant needs to provide documentation from their treating provider, or applicant has been referred to another provider for further evaluation or testing):

Explanation to **NO or Applicant Needs Further Evaluation** responses:

c. Certification Recommendation: Based on the results of the evaluation and assessment, above, I:

Recommend medical certification ☐ **DO NOT recommend** medical certification ☐ **Recommend further review** of this application at the National Maritime Center ☐

Please explain your recommendation:

d. Medical Practitioner: My signature attests, subject to criminal prosecution under 18 U.S.C. § 1001, that all information reported by me is true and correct to the best of my knowledge and that I have not knowingly omitted or falsified any material information relevant to this form. My signature also attests that I have fully evaluated all examination tests and results submitted in support of this application.

Signature of Medical Practitioner

Date of Signature (MM/DD/YYYY)

MD ☐ DO ☐ PA ☐ NP ☐

Last Name

First Name

M.I.

Office Street Address

License Number

State where Licensed

City

State

Zip Code

Office Phone Number

(Place office address stamp here)

Section X: Applicant Certification - To be completed by the Applicant

My signature below attests, subject to prosecution under 18 U.S.C. § 1001, that all information provided by me on this form is complete and true to the best of my knowledge, and I agree that it is to be considered part of the basis for issuance of any medical certificate to me. I have not knowingly omitted any material information relevant to this form. I have also read and understand the Privacy Act Statement that accompanies this form.

Signature of Applicant (NOTE: Applying your electronic signature here will LOCK this form.)

Date of Signature (MM/DD/YYYY)

Print Applicant Name:*(Last, First, MI.)*

Date of Birth: *(MM/DD/YYYY)*

Section XI: (Optional) Third Party Authorization - To be completed by the Applicant

Declined ☐

a. CONSENT FOR MEDICAL PRACTITIONER TO RELEASE INFORMATION TO THE COAST GUARD:

I authorize the Medical Practitioner who completed this form to release my medical information to Coast Guard medical evaluation personnel.

I understand that this authorization is voluntary. I also understand that failure to provide authorization could delay timely evaluation of my application for medical certificate. This authorization will remain in effect for one year from the date signed below.

I have read and understand the following statements about my rights:

1. I may revoke this authorization at any time prior to its expiration date by notifying the verifying medical practitioner in writing, but the revocation will not have any effect on any actions taken before they received the notification.
2. Upon request, I may see or copy the information described in this release.
3. I am not required to sign this release to receive my medical evaluation.

Signature of Applicant ____________________

Date of Signature (MM/DD/YYYY) ____________________

b. CONSENT FOR COAST GUARD TO RELEASE MY INFORMATION TO A THIRD PARTY:

My signature authorizes the Coast Guard to share my medical information with the third party indicated below. This authorization will remain in effect for one year from the date signed below. I understand that I may revoke this authorization at any time prior to its expiration date by notifying the Coast Guard in writing.

Please provide the Name of the Organization or Third Party, Address, and Phone Number. Additional Third Party Authorization information may be attached separately.

Name of Organization or Third Party ____________________

Organization Point of Contact *(if applicable)* ____________________

Phone Number ____________________

Street Address ____________________

City ____________________

State ____________________

Zip Code ____________________

Signature of Applicant ____________________

Date of Signature (MM/DD/YYYY) ____________________

c. CONSENT FOR THIRD PARTY TO ACT ON MY BEHALF:

I authorize the following third party **to act on my behalf** in all matters pertaining to the processing **of my current application for a medical certificate**. This means that:

1. the Coast Guard will share my medical information and correspondence with the third party, **and**
2. the **third party can request agency action** on my behalf.
3. If you also want to authorize the third party **to receive your medical certificate**, please initial here **AND** indicate their name and address in Section I, question 5c. ____ Initial

This authorization will remain in effect for one year from the date signed below. I understand that I may revoke this authorization at any time prior to its expiration date by notifying the Coast Guard in writing. Please provide the Name of the Organization or Third Party, Address, and Phone Number. Additional Third Party Authorization information may be attached separately.

Name of Organization or Third Party ____________________

Organization Point of Contact *(if applicable)* ____________________

Phone Number ____________________

Street Address ____________________

City ____________________

State ____________________

Zip Code ____________________

Signature of Applicant ____________________

Date of Signature (MM/DD/YYYY) ____________________

Print Applicant Name:*(Last, First, MI.)* ____________________ Date of Birth: *(MM/DD/YYYY)* ____________________