DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD

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APPLICATION FOR MEDICAL CERTIFICATE, SHORT FORM (FORM CG-719K/E)

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

Who must submit this form?

1. Mariners applying for or holding a Merchant Mariner Credential (MMC) with only an entry-level national endorsement or a staff officer national endorsement **who want to serve as Food Handler** may use this form. Please include this instruction page in addition to sections I, II, V and VI of this form.

2. Mariners applying for or holding an MMC with only an entry-level endorsement or a staff officer endorsement who require a medical certificate that complies with the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (**STCW**) or, Maritime Labour Convention (**MLC**) requirements and **will not stand navigational or engineering watches** may apply using this form. No lookout duties will be authorized.

3. All other applicants for a Medical Certificate must use the Application for Medical Certificate, Form CG-719K.

4. 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.

Who may conduct this exam?

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.

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, Section VI, on page 4 of this form.

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 U.S. Coast Guard (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).

General Instructions for the Medical Practitioner

1. Complete all portions of the application marked "To be completed by the Medical Practitioner." Incomplete applications 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 application. Initial and date each page of this application in the area designated to acknowledge that you have reviewed the information provided and to ensure application integrity.

3. Review the medical evaluation guidance contained in the Merchant Mariner Medical Manual, COMDTINST M16721.48, which can be found here: https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF

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)

Applicant Address and Contact Information ***(Please indicate best method(s) of contact by checking the appropriate box(es)).***

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

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

Home Address ☐ Mailing Address ☐ Other Address ☐

Specify Other Address Here

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).

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* ☐

Section III: Physical information - To be completed by the Medical Practitioner

Height (*Feet and Inches)* Weight *(pounds)*

Distinguishing Marks: *(Please Print)*

MEDICAL PRACTITIONER INITIALS: _____ **DATE OF EXAM**: _____

Section IV: 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.	Has the strength, dexterity and stamina to manipulate mechanical devices. 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.	Fulfills the eyesight standard for the merchant mariner credential(s) applied for. See Chapter 5 of the Merchant Mariner Medical Manual.
React to audible alarms, warnings, and instructions; emergency response procedures	Fulfills the hearing standard for the merchant mariner credential(s) applied for. See Chapter 5 of the Merchant Mariner Medical Manual.
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.

Table 1 to 46 CFR 10.302(a) requires that ratings, including entry level, and food handler serving on vessels to which STCW applies must provide a demonstration of physical ability. For an applicant to pass a demonstration of physical ability, the examiner must be satisfied that the applicant is able to perform each of the activities described in the table above. The examining medical practitioner may test the listed skills directly, or may utilize alternative measures to evaluate the applicant's abilities. The medical practitioner should provide description of any alternative measures used and any assistive devices required.

The seafaring life is arduous, often hazardous and the availability of medical assistance or treatment is generally minimal. All mariners should be capable of living and working in cramped spaces, frequently in adverse weather causing violent evolutions; and all should be capable of physical labor and responding to emergencies such as firefighting or launching lifeboats or life rafts. Guidance on the Physical Ability Guidelines can be found in the Merchant Mariner Medical Manual, available at: https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF.

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 V: 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: 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 ☐

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 ☐

If you checked **DO NOT Recommend** or **Recommend further review**, please explain your concerns:

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 VI: 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)

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.

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

Section VII: *(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)*