American Steamship Company

Centerpointe Corporate Park
500 Essjay Road
Williamsville, New York 14221

Phone: 716-635-0222
Fax: 716-635-0220
www.americansteamship.com

A subsidiary of GATX Corporation

TO: Liberty & AMO Employees & Applicants
From: ASC Human Resources
RE: 2016 Annual Physicals

Please carefully read through the enclosed physical paperwork. **IT HAS CHANGED**. The 719K Form has been revised by the USCG. Do not have a physical exam unless instructed by Human Resources or your dispatcher to do so.

You may use an Occupational Health clinic in your area, but the clinic you choose must be able to complete all components of the physical protocol, including the proper vision and hearing test in conjunction with the FORM 719-k. **Remember, we will NOT pay for CBC's (Complete Blood Chemistry), as this is NOT part of the physical protocol**. Please tell your doctor not to conduct this test unless you pay for it up front. Keep in mind, this is your annual work physical, and should not be used as your annual physical with your personal doctor through your insurance.

The enclosed paperwork includes the Physical Cover Letter with **Physical Exam Protocol which outlines the components of your physical.** It also lists the tests that the company is not liable to pay for. The release of information needs to be completed by you so that your physician may forward your physical results to our Medical Review Officer, Dr. Douglas Wendland, at St. Luke's. Also enclosed is the Authorization to Discuss Pertinent Medical Information with the USCG. By completing this document, you will authorize Dr. Wendland to discuss your medical information with the USCG if they have questions regarding your physical in order to clear you. **Please take all of this paperwork with you the day of your physical.**

Required paperwork

1. Cover letter and protocol form
2. CG-719K
3. CG-719K addendum
4. Authorization to Discuss Pertinent Medical Information with the United States Coast Guard
5. Authorization to Release Medical information.

Required components

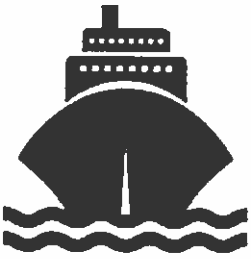
- Physical Exam using the CG – 719K form - Employee must KEEP the completed original
- Height, Weight & Vital Signs
- BMI – note section VIII if your BMI is 40 or higher you will need to demonstrate physical ability as out-lined on page 8. These results must be reported in section IX.
- Vision – Near, Far, and color
- Urine Dip Stick – please note form Addendum to CG719K this needs to be completed and sent to St Luke's along with your physical. **Your physical cannot be cleared without the urine dip stick.**

- Hearing – If whisper Test is not passed, proceed to audiogram
- Pulmonary Function Testing – **ONLY** Utility men, Conveyor men, Wiper/ Gate men
- 1. TST (Mantoux) or Quantiferen – TB Blood Test ….**ONLY** food Handlers/Galley workers **(ALL GVUP's must have this test)**
  2. Hepatitis A Vaccine (If not vaccinated)…. **ONLY** food Handlers/Galley workers **(ALL GVUP's must have this test)**
  3. Document free from communicable disease on Addendum… ONLY food Handlers/Galley Workers **(ALL GVUP's must have this test)**

If your Occupational Health Clinic has a question during your physical, have them contact St. Luke's Occupational health at 218-249-6822.

The clinic should fax all paperwork to St Luke's but should give YOU THE ORIGINAL exam to take home with you.

St. Luke's
Occupational Health
4702 Grand Av
Duluth MN 55807
P: 218-249-6822
F: 218-249-6828



NVIC Review FAX Cover Letter

Fax to 218-249-6828

BEFORE FAXING

Please **check all the following:**

- ☐ **1. ALL Sections are complete**
- ☐ **2. IF corrected vision – MUST also enter uncorrected vision**
- ☐ **3. Color Vision - Need METHOD, RESULT, & NUMBER OF ERRORS**
- ☐ **4. Only do Audio if abnormal whisper test or if hearing aid required.**
- ☐ **5. If BMI 40.0 or higher, a BMI Assessment is REQUIRED.**
- ☐ **6. Make sure a dipstick urine has been completed**
- ☐ **7. IF a Galley worker – Tuberculosis testing is required**

Date _____

Number of Pages _____

Fax to 218-249-6828

St. Luke's
Occupational Health

4702 Grand Avenue
Duluth, MN 55807
P: 218 249-6822
F: 218 249-6828

2016
AUTHORIZATION to RELEASE MEDICAL INFORMATION

Complete all areas with a large X

Name X _____ **SS#** X _____ **DOB** X _____

Employer **American Steamship/Liberty Steamship**

Request release of information **FROM:**

X Clinic Name
X Address
X City, State, Zip
X Phone / X FAx

To be released **TO:**

St. Luke's Occupational Health
Attn: Deb Slater, Medical Records
4702 Grand Av
Duluth, MN 55807

FAX to 218-249-6828

Release the following information:

☑ **2014-2015 Merchant Marine Physical Exam & ALL Ancillary Testing**

X **DATE(S) of SERVICE** _____

Reason for release: (Check all that apply)

☑ Employment (annual physical)

☐ Other:

All information regarding mental health, chemical dependency, HIV, alcohol, or sickle cell anemia will be released unless you restrict here by checking the appropriate area and initialing your restriction action. **Please *Exclude*:**

☐ Mental Health ☐ Chemical Dependency ☐ HIV ☐ Alcohol Abuse ☐ Sickle Cell Anemia **Please Initial** _____

- I understand this authorization will remain in effect for one (1) year from the date of signature, or until the following date or event: _____.
- I also understand this authorization may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith. A request for revocation or questions about disclosures may be sent to the address listed above.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules.
- I understand authorizing disclosure of my medical information is voluntary; I can refuse to sign this authorization and still be assured treatment.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.

X _____ X _____

Signature of Patient *or* Authorized Representative **Date**

If Authorized Representative, relationship to patient is _____

St. Luke's
Occupational Health

4702 Grand Avenue
Duluth, MN 55807
P: 218 249-6822
F: 218 249-6828

2016
Authorization
To Discuss Pertinent Medical Information
with the
U.S. COAST GUARD

Complete all areas with a large X

Name X _____

SS# X _____ **DOB** X _____

Employer American Steamship/Liberty Steamship

I hereby authorize St. Luke's Occupational Health to release to, or discuss with, the US Coast Guard any pertinent information in his/her possession regarding any physical or medical condition that may require review by the Coast Guard prior to determining whether the Coast Guard should issue a credential(s) for maritime service.

I understand that this authorization is voluntary. I also understand that failure to provide authorization could affect the Coast Guard's ability to make a timely determination as to whether the Coast Guard should issue me a credential(s) for maritime service. This authorization will remain in effect until the Coast Guard determines whether to issue me the requested credential(s) for maritime service, but no longer than one year.

All information regarding mental health, chemical dependency, HIV, alcohol, or sickle cell anemia will be released unless you restrict here by checking the appropriate area and initialing your restriction action.

☐ Mental Health ☐ HIV ☐ Sickle Cell Anemia

☐ Chemical Dependency ☐ Alcohol Abuse **Initial to Exclude** _____

- I understand this authorization will remain in effect for one (1) year from the date of signature, or until the following date or event:

  _____.
- I also understand this authorization may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith. A request for revocation or questions about disclosures may be sent to the address listed above.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.
- I have read and understand the following statement about my rights.
- Upon request, I may see or copy information described in this release.
- I am not required to sign this release to receive my medical evaluation.

X _____ X _____

Signature of Patient *or* **Authorized Representative** **Date**

If Authorized Representative, relationship to patient is _____

American Steamship/Liberty Steamship

ADDENDUM to CG-719K

SAILOR COMPLETES: Name_____ DOB_____

How do you wish to be contacted? Please include contact information below:

Address _____ Home Phone _____

_____ Cell Phone _____

_____ e-mail _____

Job Title:_____

CLINIC COMPLETES:

URINE TEST:	Blood	Protein	Sugar	Specific Gravity
Date_____				

TST (Mantoux) - - - *ONLY* for Food Handlers/Galley Workers

Date/Time Given	**Date/Time Read**
0.1 ml PPD	Lot#
L R Forearm	_____mm Induration
Given By	Read By

I certify that this **Food Handler/Galley Worker** is free from communicable disease.

*Medical Provider's Signature*_____

MEDICAL PROVIDER COMPLETES:

Medical Provider Name (Printed) _____

Medical License# _____

Medical Provider Address _____

_____

_____

Office Phone Number _____

FAX with CG-719K to St. Luke's Occupational Health at **218-249-6828**

AMERICAN STEAMSHIP COMPANY
LIBERTY STEAMSHIP COMPANY

Centerpointe Corporate Park
500 Essjay Road
Williamsville, NY 14221-8226

Respiratory Medical Evaluation Questionnaire

ONLY for: (check one)
- ☐ Wiper/Gatemen
- ☐ Conveyor Men
- ☐ Utility Maintenance Men

Must Be Completed Using PEN! Pencil Not Accepted.

Date_____

Section 1

NAME_____ AGE____ DATE of BIRTH_____ SEX M F Ht_____ Wt_____

ADDRESS_____ SS#_____

JOB TITLE_____

HOME PHONE_____ Best time to call_____ WORK PHONE_____ Best time to call_____

___Yes___No **Has your employer told you how to contact the health care professional who reviews this questionnaire?**

___Yes___No **Have you worn a respirator?**

Check the type of respirator you will use (you can check more than one category):

___N,R,P disposable respirator (filter-mask, non-cartridge type only)
___Other type (for example, half or full facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

How often are you expected to use a respirator? (check all that apply):

___Yes___No Escape only, no rescue
___Yes___No Emergency rescue only
___Yes___No Less than 5 hours per week
___Yes___No 2-4 hours per day
___Yes___No Less than 2 hours per day

Section 2

___Yes___No **Do you currently smoke?**

___Yes___No **Have you ever smoked?**
If yes, when did you last smoke?

___Yes___No **Have you smoked a cigarette within the past hour?**

___Yes___No **Have you used a fast acting bronchodilator within the last 2 hours?**

Have you ever had the following conditions?

___Yes___No Seizures (fits)
___Yes___No Trouble smelling odors
___Yes___No Claustrophobia (fear of closed in places)
___Yes___No Diabetes (sugar disease)
___Yes___No Allergic reactions that interfere with your breathing

Have you ever had any of the following pulmonary or lung problems?

___Yes___No Asbestosis
___Yes___No Asthma
___Yes___No Chronic bronchitis
___Yes___No Emphysema
___Yes___No Silicosis
___Yes___No Lung cancer
___Yes___No Pneumonia
___Yes___No Tuberculosis
___Yes___No Broken ribs
___Yes___No Chest injuries or surgeries
___Yes___No Pneumothorax (collapsed lung)
___Yes___No Any lung problem you've been told about

Do you currently have any of the following symptomsof pulmonary or lung illness?

___Yes___No Shortness of breath
___Yes___No Shortness of breath when walking fast on level ground or or walking up a slight hill or incline
___Yes___No Shortness of breath when walking with other people at an ordinary pace on level ground
___Yes___No Have you ever had to stop for breath when walking at pace on level ground
___Yes___No Shortness of breath when washing or dressing yourself
___Yes___No Shortness of breath that interferes with your job
___Yes___No Coughing that produces phlegm (thick sputum)
___Yes___No Coughing that wakes you early in the morning
___Yes___No Coughing that occurs mostly when you are lying down
___Yes___No Coughing up blood in the past month
___Yes___No Wheezing
___Yes___No Wheezing that interferes with your job
___Yes___No Chest pain when you breathe deeply
___Yes___No Any other symptoms that you think may be related to lung problems (If Yes, list)

Section 2 continued

Have you ever had any of the following cardiovascular or heart problems?

___Yes___No Heart attack
___Yes___No Stroke
___Yes___No Angina
___Yes___No Heart failure
___Yes___No High blood pressure
___Yes___No Swelling in your legs or feet, not caused by walking
___Yes___No Heart arrhythmia (heart beating irregularly)
___Yes___No Any other heart problem that you have been told about

Have you ever had any of the following cardiovascular or heart symptoms?

___Yes___No Pain or tightness in your chest that interferes with your job
___Yes___No In the past 2 years, have you noticed your heart skipping or missing a beat
___Yes___No Heartburn or indigestion that is not related to eating
___Yes___No Any other symptoms that you think may be related to heart or circulation problems
___Yes___No Frequent pain or tightness in your chest

Do you currently take medications for any of the following problems?

___Yes___No Breathing or lung problems
___Yes___No Heart
___Yes___No Blood pressure
___Yes___No Seizures (fits)

If you have used a respirator, have you ever had any of the following problems?

___ Check here if you have ***never used a respirator*** and proceed to **Section 3**

___Yes___No Eye irritation
___Yes___No Skin allergies or rashes
___Yes___No Anxiety
___Yes___No General weakness or fatigue
___Yes____No Any other problem that interferes with your use of a respirator?

Section 3:

___Yes___No **At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?**

Have you ever worked with any of the materials, or under any of the following conditions:

___Yes___No Asbestos
___Yes___No Tin
___Yes___No Iron
___Yes___No Berylium
___Yes___No Aluminum
___Yes___No Dusty environments
___Yes___No Coal (such as mining)
___Yes___No Silica (used in sandblasting)
___Yes___No Tungsten/cobalt (grinding or welding this material)
___Yes___No Any other hazardous exposures If yes, describe:

List any second jobs or side businesses you have:

List your previous occupations:

List your current and previous hobbies:

___Yes___No **Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over the counter medications)?**

Will you be using any of the following items with your respirator(s)?

___Yes___No HEPA Filters
___Yes___No Canisters (for example, gas masks)
___Yes___No Cartridges

_____ Employee Signature

_____ Date

St. Luke's Occupational Health Use Only. Reviewed by: Date:

American Steamship Company/Liberty Steamship Company

2016 Physical Exam Cover Letter with Physical Exam Protocol

Required Components

Company pays for ONLY these components.

Physical Exam using **NEW** CG-719K form..... *(employee **MUST** take the completed ORIGINAL)*
Height, Weight & Vital Signs
BMI
Vision (Near, Far, & Color)
Urine Dipstick
Hearing..... If Whisper Test not passed, proceed to Audiogram
ONLY Utility men, Conveyormen, Wiper/Gate men . Pulmonary Function Testing
ONLY Food Handlers/Galley Workers
1. TST (Mantoux) ***or*** T-Spot or QuantiFERON Gold-TB Blood Test
2. Hepatitis A Vaccine (if not yet vaccinated)
3. Document free from communicable disease on Addendum

Employees are financially responsible for ANY additional testing listed below

Annual Certification Requirements

Your annual physical will be reviewed by St. Luke's Occupational Health.

If you have any of the conditions listed to the right, please submit the appropriate additional information listed *with* your physical exam.

BLOOD DISORDERS
Annual follow-up with primary provider
CBC

CIRCULATORY
MI/CAD
Annual cardiology consult
EST every 2 years (CABG- every 2 yrs after 5)

Rhythm disorders requiring continuous treatment
Annual cardiology consult
INR records for last 30 days (if applicable)

Valvular disease
Annual cardiology consult
Aortic stenosis - echo annually
Aortic regurg - echo every 2 years
INR records for last 30 days (if applicable)

Congestive Heart Failure
Annual cardiology consult
Annual echo

Aneurysms
Annual cardiology or vascular surgery consult
Annual US

Peripheral vascular disease
Annual follow-ups with primary physician

DVT
Annual follow-up with primary physician
INR records for last 30 days (if applicable)

Defibrillators
Cardiology consult note within last 12 months
Echocardiogram or other method to measure EF
Exercise Cardiac Stress Test within last 12 months

ENDOCRINE
Diabetes - Annual follow-up with primary physician
HgA1C < 90 days old

Thyroid disease Annual TSH

EYES
Glaucoma - Annual ophthalmology consult

GASTROINTESTINAL
Hepatitis
Annual follow-up by primary provider
Annual LFTs (for Hepatitis B and C until "cured") *cont.*

GASTROINTESTINAL continued
Gastrointestinal pathology requiring continued treatment
Annual gastrology or internal medicine consult

HIV Annual follow-up with primary provider
Viral load
CD4 count

KIDNEY DISEASES
Annual follow-up with primary provider
Annual serum Creatinine

MUSCULOSKELETAL
Statement from examining provider about function of affected area

NEUROLOGIC
TIA, cerebral hemorrhage, intracranial aneurysm, cerebral thrombosis
Annual neurological consult for 5 years post event

Deteriorating neurological conditions
Annual neurology consult to asses function

Seizure disorders
Annual neurology consult addressing control of seizure disorder

PSYCHIATRIC
All conditions except mild depression- annual mental health provider consult with statement of control of condition and efficacy and tolerance of medications.

Substance abuse
Statement from primary provider addressing control of substance abuse.

RESPIRATORY
Asthma (requiring ER treatment in last 2 years)
Pulmonology consult
Pulmonary Function Test

Chronic bronchitis/ Emphysema/ COPD
Annual Pulmonary Function Test and pulse oximetry

Obstructive Sleep Apnea
Annual follow-up with primary care provider documenting efficacy of treatment

TUBERCULOSIS (history of active or latent)
Annual review of symptoms by primary care provider

Results: **Fax to** (218-249-6828) or **e-mail** (occupationalhealth@slhduluth.com)

Please do NOT Fax AND e-mail

1. ALL medical information required for this exam.
2. Signed Release of Information to Attn: Medical Records, St. Luke's Occupational Health

(Call 218-249-6822 with ANY questions)

Billing: Billing for Required Components ONLY to ..... Attn: Mary Banks Phone: 716-635-1371

American Steamship Company
500 Essjay Rd
Williamsville NY 14221

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

OMB No. 1625-0040
Exp. Date: 01/31/2016

APPLICATION FOR MERCHANT MARINER MEDICAL CERTIFICATE

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

Remove Instructions before submitting Application

Who must submit this form?

Applicants seeking a Medical Certificate are required to complete this form and submit it to the U.S. Coast Guard. Applicants seeking a raise-in-grade are required to submit this form if a previous medical evaluation report has not been submitted within the last 3 years. Guidance for required submission of this form can be found at the National Maritime Center website (**http://www.uscg.mil/nmc/medical/default.asp**).

The Coast Guard requires a physical examination and certification be completed to ensure that mariners:

- Are of sound health.
- Have no physical limitations that would hinder or prevent performance of duties *(see below)*.
- Are free from any medical conditions that pose a risk of sudden incapacitation, which would affect operating, or working on vessels.

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

- **Legal Name** - Enter complete legal name.
- **Date of Birth** - If applicant is under 18 years of age, notarized statement from legal guardian is required. Attach a notarized statement, signed by a parent or guardian, authorizing the Coast Guard to issue a Medical Certificate.
- **Reference Number** - If you have been credentialed by the Coast Guard in the past, enter your reference number.
- **Gender** - Enter your legal gender.
- **Home Address** - Principle place of residence. PO Box is not acceptable.
- **Delivery/Mailing Address** - The address to which you want all correspondence and issued certificates sent. If blank, correspondence and credentials will be sent to the Home Address.
- **Primary Phone Number** - Provide a primary phone number.
- **Alternate Phone Number** - Provide an alternate phone number *(optional)*.
- **E-mail Address** - The National Maritime Center *(NMC)* may attempt to contact you via e-mail. You will receive automated updates regarding the status of your application *(optional)*.
- **Other** - Please provide additional means of communicating with you *(satellite phone, work phone, etc.) (optional)*.
- **Application Type** - Self-explanatory.

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

Conditions 1 - 34 - Applicants must report their relevant medical conditions to the best of their knowledge, and the **Medical Practitioner** must verify the medical conditions. Check "YES" if the applicant has had a previous diagnosis or treatment of the condition by a health care provider, or if the applicant is currently under treatment or observation for the condition, or if the condition is present regardless of treatment. If the **Medical Practitioner**, or any other health care provider to the satisfaction of the medical practitioner, discovers a condition not reported by the applicant, he/she must check "YES" in the appropriate block and explain in the comments.

Comments - The **Medical Practitioner** must address all reported conditions in this section. This detailed explanation should include, at a minimum, identification of the condition, approximate date of diagnosis, any limitations, whether the condition is controlled, the prognosis, the treatment, and any additional information as appropriate, referring to the evaluation data listed at the National Maritime Center (NMC) website **http://www.uscg.mil/nmc/medical/default.asp**. Additional sheets may be added by the applicant and/or the medical practitioner if needed to complete this section of the form. Include applicant's name and DOB on each additional sheet. Supporting medical documentation and testing for all identified conditions potentially requiring further review should be submitted with each application as per the guidelines found on the NMC website **http://www.uscg.mil/nmc/medical/default.asp**. Detailed guidelines on medical conditions subject to further review can be found on the NMC website. Medical practitioners should be familiar with the guidelines contained within this document. Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials can be downloaded from the NMC website or by calling the NMC at 1-888-IASKNMC (1-888-427-5662).

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

Review by the Medical Practitioner - 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.

Section IV: (Vision) and V: (Hearing) - To be completed by the Medical Practitioner or other staff to the satisfaction of the Medical Practitioner

The **Medical Practitioner** is not required to perform or witness every examination, test, or demonstration. These may be referred to other qualified practitioners such as audiologists or optometrists; however, they must be reviewed to the satisfaction of the Medical Practitioner.

All examinations, tests and demonstrations must be performed, witnessed, or reviewed by a physician *(Medical Doctor [MD], or Doctor of Osteopathy [DO])*, or nurse practitioner, or a certified physician assistant licensed by a state in the U.S., a U.S. possession, or a U.S. territory. The **Medical Practitioner** who performs the examination must review Sections II and III of this form.

Section VI: Physical Examination - Items 1-17; To be completed by the Medical Practitioner

Self-explanatory

Section VII: 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 Tasks, Function, Event, or Condition	*Related Physical Ability*	*Acceptable Demonstration*
Routine movement on slippery, uneven, and unstable surfaces	Maintain balance *(equilibrium)*	Has no disturbance in sense of balance
Routine access between levels	Climb up and down vertical ladders and stairways	Is able, without assistance, to climb up and down vertical ladders and stairways
Routine movement between spaces and compartments	Step over high doorsills and coamings, and move through restricted accesses	Is able, without assistance, to step over a doorsill or coaming of 24 inches (600 millimeters) in height. Able to move through a restricted opening of 24 x 24 inches
Open and close watertight doors, hand cranking systems, open/close valve	Manipulate mechanical devices using manual and digital dexterity, and strength	Is able, without assistance, to open and close watertight doors that may weigh up to 55 pounds (25 kilograms); should be able to move hands/arms to open and close valve wheels in vertical and horizontal directions; rotate wrists to turn handles; able to reach above shoulder height
Handle ship's stores	Lift, pull, push, carry a load	Is able, without assistance, to lift at least a 40 pound (18.1 kilograms) load off the ground, and to carry, push, or pull the same load
General vessel maintenance	Crouch *(lowering height by bending knees)*; kneel *(placing knees on ground)*; stoop *(lowering height by bending at the waist)*; use hand tools such as spanners, valve wrenches, hammers, screwdrivers, pliers	Is able, without assistance, to grasp, lift, and manipulate various common shipboard tools
Emergency response procedures including escape from smoke-filled spaces	Crawl *(ability to move body using hands and knees)*; feel *(ability to handle or touch to examine or determine differences in texture and temperature)*	Is able, without assistance, to crouch, kneel, and crawl, and to distinguish differences in texture and temperature by feel
Stand a routine watch	Stand a routine watch	Is able, without assistance, to intermittently stand on feet for up to four hours with minimal rest periods
React to visual alarms and instructions, emergency response procedures	Distinguish an object or shape at a certain distance	Fulfills the eyesight standards for the merchant mariner credential applied for (see www.uscg.mil/nmc for more info)
React to audible alarms and instructions, emergency response procedures	Hear a specified decibel (dB) sound at a specified frequency	Fulfills the hearing standards for the merchant mariner credential applied for
Make verbal reports or call attention to suspicious or emergency conditions	Describe immediate surroundings and activities, and pronounce words clearly	Is capable of normal conversation
Participate in fire fighting activities	Be able to carry and handle fire hoses and fire extinguishers	Is able, without assistance, to pull an uncharged 1.5 inch diameter, 50' fire hose with nozzle to full extension, and to lift a charged 1.5 inch diameter fire hose to fire fighting position
Abandon ship	Use survival equipment	Has the agility, strength, and range of motion to put on a personal flotation device and exposure suit without assistance from another individual

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

The Medical Practitioner shall complete Section VIII for all applicants requiring Food Handler Certification. The Medical Practitioner need not perform any additional laboratory 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. The following issues should be considered by the Medical Practitioner when certifying an applicant:

a. The applicant reports they have been diagnosed with an illness due to organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc.

b. 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. 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.

d. The applicant reports they have had Salmonella Typhi within the past three months, Shigella spp. within the past month, Shiga-toxin-producing Escherichia coli within the past month, or Hepatitis A virus ever.

e. The applicant reports they are suspected of causing or being exposed to a confirmed disease outbreak caused by organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc. This would include outbreaks associated with events such as a family meal, church supper, or festival because the employee ate food implicated in the outbreak, or ate food at the event prepared by a person who is infected or who is suspected of being a shedder of the infectious agent.

f. The applicant reports they live in the same household as, and have knowledge about, a person who is diagnosed with organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc.

g. The applicant reports they live in the same household as, and have knowledge about, a person who attends or works in a setting where there is a confirmed disease outbreak caused by organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc.

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

Proof of Identity

a. **Applicants** shall present acceptable proof of identity to the Medical Practitioner conducting examinations.

b. Proof of identity shall consist of one current form of valid government issued photo identification.

c. The following credentials are examples of acceptable proof of identity: 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's Document/Merchant Mariner Credential, or Transportation Worker Identification Credential.

Overall fitness recommendation: The **Medical Practitioner** must ensure a complete history and physical are conducted and make recommendations as to the fitness of the applicant. Final approval of the mariner's status rests with the U.S. Coast Guard.

Medical Practitioner: Certification that the general medical examination, vision and hearing tests, as well as the physical demonstration of competence as appropriate, have been performed to the satisfaction of the **Medical Practitioner**. The **Medical Practitioner** must sign and date the certification where indicated. This signature attests, subject to criminal prosecution under 18 USC § 1001, that all information reported by the medical practitioner is true and correct to the best of his/her knowledge and that the medical practitioner has not knowingly omitted or falsified any material information relevant to this form.

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

Self-explanatory

PRIVACY ACT STATEMENT

Authority: 5 U.S.C. 301; 14 U.S.C. 632; 46 U.S.C. 2103, 7101, 7302, 7305, 7313, 7314, 7316, 7317, 7319, 7502, 7701, 8701, 8703, 9102; 46 C.F.R. 12.02; 49 C.F.R. 1.45, 1.46

Purpose: The principal purpose for which this information will be used is to determine domestic and international qualifications for the issuance of merchant mariner credentials. This includes establishing eligibility of a merchant mariner's credential, duplicate credentials, or additional endorsements issued by the Coast Guard and establishing and maintaining continuous records of the person's documentation transactions.

Routine Uses: The information will be used by authorized Coast Guard personnel with a need to know the information to determine whether an applicant is a safe and suitable person who is capable of performing the duties of the Merchant Mariner. The information will not be shared outside of DHS except in accordance with the provisions of DHS/USCG-030 Merchant Seamen's Records System of Records, 74 FR 30308 (June 25, 2009).

Disclosure: Furnishing this information (including your SSN) is voluntary; however, failure to furnish the requested information may result in non-issuance of the requested credential.

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

OMB No. 1625-0040
Exp. Date: 01/31/2016

APPLICATION FOR MERCHANT MARINER MEDICAL CERTIFICATE

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

Last Name | First Name | Middle Name | Suffix *(Jr., Sr., III)*

Reference Number *(if applicable)* | Gender: ☐ Male ☐ Female | Date of Birth (MM/DD/YYYY)

Please indicate best method(s) of contact by checking the appropriate box(es). Optional if information is same as most recent CG-719B.

Home Address ***(PO Box NOT acceptable)*** ☐
Street Address | Primary Phone Number ☐

City | State | Zip Code | Alternate Phone Number ☐

Delivery/Mailing Address, if different ***(PO Box acceptable)*** ☐ | E-mail Address ☐
Street Address

City | State | Zip Code | Other ☐

Application Type: ☐ Medical Certificate ☐ First Class Pilot

I have a medical waiver: ☐ Yes ☐ No If YES, provide a copy of the medical waiver to the Medical Practitioner.

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

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

☐ Yes ☐ No 1. Eye/vision problems except glasses
☐ Yes ☐ No 2. Ear/nose/throat problems or other ENT problems/surgery
☐ Yes ☐ No 3. High or low blood pressure
☐ Yes ☐ No 4. Heart or vascular disease of any kind
☐ Yes ☐ No 5. Heart surgery and/or implanted devices (pacemaker, defibrillator, etc.)
☐ Yes ☐ No 6. Lung disease of any type (asthma, bronchitis, emphysema, etc.)
☐ Yes ☐ No 7. Any blood disorder (anemia, hemophilia, blood clots, polycythemia, etc.)
☐ Yes ☐ No 8. Diabetes, glucose intolerance, or sugar in urine
☐ Yes ☐ No 9. Thyroid problem
☐ Yes ☐ No 10. Stomach, liver, or intestinal disorder
☐ Yes ☐ No 11. Kidney problems/stones or blood in urine
☐ Yes ☐ No 12. Any other urinary or bladder problems not listed above
☐ Yes ☐ No 13. Skin disorder or problem
☐ Yes ☐ No 14. Allergies or allergic reactions to any substance, medication, or food.
☐ Yes ☐ No 15. Infectious/contagious disease
☐ Yes ☐ No 16. Any sleep problems: obstructive sleep apnea, restless leg syndrome, narcolepsy, shift work sleep disorder, insomnia, etc.
☐ Yes ☐ No 17. Epilepsy, fits, or seizures
☐ Yes ☐ No 18. Loss of consciousness or memory
☐ Yes ☐ No 19. Frequent or severe headaches
☐ Yes ☐ No 20. Dizziness/fainting spells/balance problems
☐ Yes ☐ No 21. Frequent motion sickness requiring medication
☐ Yes ☐ No 22. Stroke or Transient Ischemic Attack (TIA), brain tumor or other brain disorder
☐ Yes ☐ No 23. Any neurologic disorder or nerve problems including numbness and/or paralysis, not listed above
☐ Yes ☐ No 24. Attention deficit disorder with or without hyperactivity
☐ Yes ☐ No 25. Anxiety, depression, bipolar disorder, adjustment disorder, PTSD, or schizophrenia
☐ Yes ☐ No 26. Suicide attempt or thought (ideation) of suicide
☐ Yes ☐ No 27. Evaluation, treatment, or hospitalization for alcohol or substance use, abuse, addiction, or dependence (including illegal drugs, prescription medications, or other substances)
☐ Yes ☐ No 28. Any other psychiatric disorder, mental health evaluation/ hospitalization
☐ Yes ☐ No 29. Back pain, joint problems, or orthopedic surgery
☐ Yes ☐ No 30. Amputation, prosthesis, or use of ambulatory devices (cane, walker, braces, etc.)
☐ Yes ☐ No 31. Fractures, recurrent dislocations or limitation of motion of any joint
☐ Yes ☐ No 32. Have you ever been signed off as sick or repatriated for medical reasons within the last six years?
☐ Yes ☐ No 33. Any diseases, surgeries, cancers, illnesses, or disabilities not listed on this form?
☐ Yes ☐ No 34. Any hospital admissions within the last six years not listed elsewhere in this Section?

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

Instructions: For each "YES" answer, identify the item numbers, the condition/diagnosis, date of onset or diagnosis, any treatment required or received, the current status of the condition, and any limitations due to the condition. As applicable, attach supporting documentation to verify findings. Additional sheets may be added as needed being sure applicant name and date of birth appear on each additional sheet.

Number	Additional Information *(Please Print)*

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

Applicants who are required to complete a general medical exam are required to report all prescription medications prescribed, filled or refilled, and/or taken within 30 days prior to the date that the applicant signs the CG-719K. In addition, all prescription medications, and all non-prescription (over-the-counter) medications including dietary supplements and vitamins, that were used for a period of 30 or more days within the last 90 days prior to the date that the applicant signs the CG-719K or approved equivalent form, must also be reported.

The information reported by the applicant must be verified by the verifying medical practitioner or other qualified medical practitioner to the satisfaction of the verifying medical practitioner to include the following two items: **(1)** Report all medications (prescription and non-prescription), dietary supplements, and vitamins. **(2)** Include dosages of every substance reported on this form, as well as the condition for which each substance is taken.

Additional sheets may be added by the applicant and/or medical practitioner if needed to complete this section *(include applicant name and date of birth on each additional sheet)*.

If none, check "NONE" ☐ NONE

Applicant *(Please Print)*	**Medical Practitioner** *(Please Print)*

REPORT OF MEDICAL EXAMINATION

Sections IV and V should be completed by the Medical Practitioner or other medical staff to the satisfaction of the Medical Practitioner.

Section IV: Vision

The Medical Practitioner must indicate test used and results (number of errors). Additional information must be reported in Section VII. Color sensing lenses (e.g. X-Chrome) are prohibited.

a. Visual Acuity

Distant Uncorrected	If Necessary, Distant Corrected To
Right: 20/	Right: 20/
Left: 20/	Left: 20/

Field of Vision

This applicant must have a 100-degree horizontal field of vision.

☐ Normal
☐ Abnormal

b. Color Vision ***(check one)***

The following color sense testing methodologies are acceptable

- ☐ 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
- ☐ Farnsworth D-15 Hue Test *(attach test results)* *(Engineer/radio officer/tankerman/MODU only)*
- ☐ 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 pseudoisochromatic 15 plate test (6 or less errors)
- ☐ An alternative test approved by the Coast Guard *(Indicate test)*

Color Vision Testing Results:

☐ Passed ☐ Failed Number of Errors:

If color vision test is failed, can the Applicant distinguish red, green, blue, and yellow: ☐ Yes ☐ No

Section V: Hearing

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

☐ Normal Hearing ☐ Abnormal Hearing ☐ Hearing Aid Required

(a) If hearing is abnormal, 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.

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

(c) Refer to Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials from the NMC website (http://www.uscg.mil/nmc/medical/default.asp) for further guidance. Report any additional information or comments in Section VII.

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): %

Section VI: Physical Examination - Items 1-17 of this section must be completed by the Medical Practitioner.

Height *(inches only)*: ☐ Weight *(lbs)*: ☐ Body Mass Index *(BMI)*: *(For BMI > 40 refer to Section VII)* ☐

Pulse Resting: ☐ Initial Blood Pressure: ☐ Repeat Blood Pressure *(if needed)*: ☐

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

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

Additional Medical Comments

Item	Additional Information *(Please Print)*

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

1. The Medical Practitioner shall require that the applicant demonstrate the ability to meet the guidelines contained within Section VII of the CG-719K instructions. This does not mean, for example, that the applicant must actually don an exposure suit, pull an unchanged 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 himself or herself that the applicant possesses the ability to meet the guidelines in the third 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).
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 all medical practitioners may not have the equipment necessary to test all of the tasks as listed. Equivalent alternate testing methodologies may be used. For further information, check the Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials (http://www.uscg.mil/nmc/medical/default.asp).
4. If the applicant is unable to perform any of the following functions, 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 instruction table.

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

COMMENTS: ***(Please Print)***

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

If Food Handler Certificate is sought by the applicant, is applicant free from communicable disease: ☐ Yes ☐ No

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

Applicant proof of identity provided: ☐ Yes ☐ No

Overall fitness recommendation: ☐ Fit for Duty

☐ Not Fit for Duty ☐ Needs Further Review

Comments:***(Please Print)***

Medical Practitioner:

My signature attests, subject to criminal prosecution under 18 USC § 1001, that all information reported by the medical practitioner is true and correct to the best of his/her knowledge and that the medical practitioner has 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.

Last Name | First Name | M.I. | License Number | State (MN)

Signature | Date (MM/DD/YYYY)

MD/DO ☐ PA ☐ NP ☐

Office Street Address

City | State | Zip Code

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 USC § 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 | Date (MM/DD/YYYY)