For Completion by Ship's Doctor or Master, And Hospital or Doctor Ashore, In case of illness or Injury Affecting Seafarers.

Note. Copies of This Form Should be Provided for the Seafarers' Medical Records, Ship's Master (or his Representatives), and Hospital/Doctor Ashore.

For Completion by Ship's Master:

Date (dd/mm/yy) : 31.10.2018

Surname of Patient, . BEQUILLA
Other Names: :LEOLOR ADAM MARTINEZ

Date of Birth	14.11.1988	Name of Ship	BITU ATLANTIC
Nationality	FILIPINO	Ship-owner	ATLANTIC RAINBOW SHIPPING
Seafarer's Registration N°	P1768841A	Name of Ship's Representative/Agent On Shore	KUDRAT MARITIME SDN BHD, KEMAMAN
Shipboard Position Held	4TH ENGINEER	Address/Telephone N° Of Ship's Representative On Shore	+609858 8100/ 8600/ 8900

Details of Illness / Injury. Treatment Received Onboard Ship (Enclose Attachments if Necessary)
BOIL ON BACKSIDE OF BODY, WHICH PAINS

Date of Onset of illness	30.10.2018	Date Injury Occured	
Date Work Ceased Onboard	NO		

For Completion by Hospital or Examining Doctor on Shore

Diagnosis

Date When Patient First Examined

To be completed as required and forwarded by Email & filed as hard copy on board in Bridge 4.10 folder.

Full Medical Documentation Should Be Attached As Necessary

Details of Specialised Examinations: Non infected sebaceous cyst [illegible] 3/52.

Treatment Given (Generic Names) of Drugs, Dosages, Route of Administration: [illegible] ; tid. Lefloxi ; tid. Altacef ; tid.

Further Treatment To Be Given Onboard Ship: —

Precautions To Be Taken Onboard Ship: —

Other Observation Of Hospital or Examining Doctor?: advice to operated in the hospital by a surgeon

	YES	NO		
Should See Another Doctor?	☑	☐	When? Specify Speciality, If Necessary	When he is free Surgery.
Is The illness Contagious? Or Infectious?	☐	☑	Estimated Duration Of illness	
Fit For Normal Work Now?	☑	☐		

Fit For Normal Work From ______

Fit For Restricted Work	☐	Specify	
Unfit For Work	☐	For How Many Days?	
Bed Rest Necessary	☐	For How Many Days?	

Recommended To Be
* Repatriated ☐
* Hospitalized ☐

Air Transport Recommended? Yes ☐ No ☑

Should be Accompanied? Yes ☐ No ☑

Name of Doctor (In Capital Letters, Written or Stamped), Position Held, Address, Telephone N°

Place and Date: KLINIK ALIAS K-525, Jalan Sulaimani, 24000 Kemaman, Terengganu Tel: 09-859 1040 / Fax: 09-859 8626 — 01 NOV 2018

Signature of Doctor: DR. HJ ALIAS ABDUL RAHMAN, AMN, PJK MBBS Univ Malaya OHD (HQ/08/DOC/00/371) KLINIK ALIAS K-525, Jalan Sulaimani 24000 Kemaman, Terengganu Tel: 09-859 1040 / Fax: 09-859 8626

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