MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

MERCHANT MARINER MEDICAL CERTIFICATE
APPLICATION THIRD PARTY AUTHORIZATION

I [ ] (print full name), authorize the U.S. Coast Guard National Maritime Center (NMC) to disclose information and/or records regarding my **current Merchant Mariner Medical Certificate application** to/with the Third Party authorized, to include only those boxes checked below.

This authorization does not apply to the Merchant Mariner Credential.

[X] Act on my behalf in **ALL MATTERS** and any after-issuance transactions pertaining to the processing of my current U.S. Coast Guard Merchant Mariner Medical Certificate application. I request that all documentation, including my medical certificate, be mailed to a third party address.

Or, matters specifically pertaining to

[X] Previous Merchant Mariner Medical Certificate(s).

[X] Mail my Merchant Mariner Medical Certificate to the third party listed below.

Third Party Information (*Required. This information will be used to verify third party identification.)

***Authorized Person's Name: (Last, First MI)**	**Organization: (if applicable)**
Stroud, Taleen	SUNY Maritime College
***Authorized Person's Mailing Address:**	***Authorized Person's Phone Number:**
6 Pennyfield Avenue Baylis Hall Throggs Neck, NY 10465	718-409-7212 (office) 718-409-4735 (fax)
	Authorized Person's Email Address:
	tstroud@sunymaritime.edu

This authorization expires either upon my written revocation of this authorization submitted via fax, e-mail, regular mail, or expiration of the Merchant Mariner Medical Certificate.

Mariner's Signature: _____ Date: [ ]
(MM/DD/YYYY)

Mariner's Reference Number or Last 4 of Social Security Number: [ ]