Fall 2017 New Incoming Student Health Requirements

Welcome to SUNY Maritime! Before you begin your studies at Maritime, you must complete certain requirements. The State University of New York requires that we collect this information from every student.

This Incoming Student Checklist is available for you to be sure that you are submitting all of the required health information. The information contained in this form is accessible only to the professional staff of Health Services and will not be released without the written authorization of the student or pursuant to a lawfully issued subpoena. The authority to request this information is found in section 355 of the Education Law.

Required for ALL Incoming Students:

- Student Information/Emergency Contact/Under 18 Notarization

- Immunization Records
  - MMR (2 doses required OR titer)
  - Hepatitis A (2 doses required to complete the series)
  - Hepatitis B (3 dose series)
  - Polio (minimum of 3 doses)
  - Tetanus (within the last 5 years)
  - Varicella (Chicken Pox: 2 doses or documentation of having the disease)
  - Tuberculosis (PPD – test MUST be within 6 months of entry into Maritime)
  - Meningitis Information Response Form

- Application for Merchant Mariner Medical Certificate - Physical Examination Form
  - ALL past medical history/medical conditions/allergies/surgeries/hospitalizations/injuries must be reported and documented in Section II (a) and II (b). ALL medications must be reported in Section III.
  - Color Vision Test Results must be recorded for Regimental students.
  - Forms without a Medical Practitioner signature and Applicant Signature will NOT be accepted.

- Health Attestation Form

  In Addition To The Above - Required for *Regimental Students Only*:

- Medical Disqualifying Policy for USCG Licensing (MMC) Form
- Medical Clearance Form for Indoctrination 2017

  In Addition To The Above - Required for *Athletes Only*:

- Sickle Cell Trait Policy Form
- Athletics Medical Clearance Form

Deadline to submit all medical paperwork is June 7, 2017

Please return COMPLETE PACKETS ONLY to:
SUNY Maritime College
Health Services
6 Pennyfield Avenue
Throggs Neck, NY 10465

Or fax/scan to (718) 409-5901 or email bravangel@sunymaritime.edu
REQUIRED FOR ALL STUDENTS

STUDENT INFORMATION

Name: ____________________________ Last    First    Middle

Address: __________________________ Street    City    State    Zip

Birth date: _______/_______/_______    Age: _______    Female: ____    Male: ___

E-mail: ____________________________ Preferred Phone Number: (   ) ____________

Please circle entering year: FALL 2016    Spring 2016    Summer 2016

Please circle: CIVILIAN    REGIMENT

EMERGENCY CONTACT INFORMATION

Name: ____________________________ Last    First    Middle

Address: __________________________ Street    City    State    Zip

Relationship: ______________________

Preferred Phone Number: (   ) ____________    E-mail: ____________________________

UNDER 18 NOTARIZATION

To Parents and Guardians of Applicants under Eighteen:

To procure care that may be necessary for our students and to protect the physician and institutions involved, it is necessary that you sign the consent for treatment statement. While every reasonable effort is made to contact families in the event of serious illness or injury, this is not always possible within a short period of time; therefore, the consent form is necessary to provide appropriate care.

I ____________________________ (Print Full Name of Parent/Guardian) pursuant to the authority vested in me as Parent/Guardian of ____________________________ (Print Full Name of Student), do authorize the Medical Staff at SUNY Maritime College, upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment, by any hospital, staff surgeon, physician or radiologist which they may deem necessary for the emergency care of my son/daughter (circle one).

Signed ____________________________ Date_____/_____/_____
Subscribed before me this _________ day of ____________________ 20____ Notary Public (with Seal)
IMMUNIZATION RECORDS FORM
REQUIRED FOR ALL CIVILIAN
AND
REGIMENTAL STUDENTS

STUDENT NAME: __________________________

Please submit a copy of your complete immunization records. Please be sure that you have the mandatory vaccines listed below.

M.M.R. (Measles, Mumps, Rubella) if given instead of individual immunizations:
1. ___ Dose 1 - Immunized no more than 4 days prior to first birthday. Date: ___/___/___
2. ___ Dose 2 - Immunized at least 30 days after first dose. Date: ___/___/___
3. ___ Positive titer. (Attach lab report)
4. ___ Physician documentation of having the disease. (Attach documentation)
5. ___ Born before January 1, 1957 and therefore considered immune

Measles (Rubella):
1. ___ Dose 1 - Immunized no more than 4 days prior to first birthday. Date: ___/___/___
2. ___ Dose 2 - Immunized at least 30 days after first dose. Date: ___/___/___
3. ___ Positive titer. (Attach lab report)

Mumps:
1. ___ Immunized with vaccine at 12 months or later. Date: ___/___/___
2. ___ Positive titer. (Attach lab report)

Rubella:
1. ___ Immunized with vaccine at 12 months or later. Date: ___/___/___
2. ___ Positive titer. (Attach lab report)

Hepatitis A: (Two doses required to complete the series. At least one dose must be given prior to attending Maritime)
1. ___ Dose 1. Date: ___/___/___
2. ___ Dose 2. Date: ___/___/___

Hepatitis B: (Completion of the three dose series)
1. ___ Dose 1. Date: ___/___/___
2. ___ Dose 2. Date: ___/___/___
3. ___ Dose 3. Date: ___/___/___

Polio: (Minimum 3 doses for all students 18 and under. For those 19 and over record previous doses):
1. ___ Dose 1. Date: ___/___/___
2. ___ Dose 2. Date: ___/___/___
3. ___ Dose 3. Date: ___/___/___
IMMUNIZATION RECORDS FORM
REQUIRED FOR ALL CIVILIAN
AND
REGIMENTAL STUDENTS

STUDENT NAME: ____________________________________________

Tetanus-Diphtheria (Minimum 3 doses required for all students – last dose MUST be within 5 years):
1. ___ Dose 1...........................................................................Date: __/__/__
2. ___ Dose 2...........................................................................Date: __/__/__
3. ___ Dose 3...........................................................................Date: __/__/__

Varicella (Chicken Pox: Two doses or documentation of having the disease)
1. ___ Dose 1...........................................................................Date: __/__/__
2. ___ Dose 2...........................................................................Date: __/__/__

Tuberculosis: (MUST be within 6 months of entry to Maritime)
1. ___ PPD (Mantoux).........................................................Date Administered: __/__/__
   Date Interpreted: __/__/__ Results: ________________________________
Meningitis Information Response Form

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester complete this section. No institution shall permit any student to attend the institution in excess of 30 days without complying with this law. The 30 day period may be extended to 60 days if a student can show a good faith effort to comply.

Check one box and sign below:

____ I have received the meningococcal meningitis immunization within the past 10 years.

Date Received: __________

____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risk of not receiving the vaccine and I have decided that I (my child) will not obtain immunization.

____ I will have my family physician provide the vaccine.

_________________________  ________________________
Student’s Signature                        Date

_________________________  ________________________
Parent/Guardian Signature (if under 18 years)  Date

_________________________  ________________________
Physician’s Signature/Stamp  Date

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throgs Neck, NY 10465  |  718.409.7347  |  www.sunymaritime.edu
# 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 credentialled 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: 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**

<table>
<thead>
<tr>
<th>Shipboard Tasks, Function, Event, or Condition</th>
<th>Related Physical Ability</th>
<th>Acceptable Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine movement on slippery, uneven, and unstable surfaces</td>
<td>Maintain balance (equilibrium)</td>
<td>Has no disturbance in sense of balance</td>
</tr>
<tr>
<td>Routine access between levels</td>
<td>Climb up and down vertical ladders and stairways</td>
<td>Is able, without assistance, to climb up and down vertical ladders and stairways</td>
</tr>
<tr>
<td>Routine movement between spaces and compartments</td>
<td>Step over high doorills and coamings, and move through restricted accesses</td>
<td>Is able, without assistance, to step over a doorill or coaming of 24 inches (600 millimeters) in height. Able to move through a restricted opening of 24 x 24 inches</td>
</tr>
<tr>
<td>Open and close watertight doors, hand cranking systems, open/close valve</td>
<td>Manipulate mechanical devices using manual and digital dexterity, and strength</td>
<td>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</td>
</tr>
<tr>
<td>Handle ship's stores</td>
<td>Lift, pull, push, carry a load</td>
<td>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</td>
</tr>
<tr>
<td>General vessel maintenance</td>
<td>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, pilers</td>
<td>Is able, without assistance, to grasp, lift, and manipulate various common shipboard tools</td>
</tr>
<tr>
<td>Emergency response procedures including escape from smoke-filled spaces</td>
<td>Crawl (ability to move body using hands and knees); feel (ability to handle or touch to examine or determine differences in texture and temperature)</td>
<td>Is able, without assistance, to crouch, kneel, and crawl, and to distinguish differences in texture and temperature by feel</td>
</tr>
<tr>
<td>Stand a routine watch</td>
<td>Stand a routine watch</td>
<td>Is able, without assistance, to intermittently stand on feet for up to four hours with minimal rest periods</td>
</tr>
<tr>
<td>React to visual alarms and instructions, emergency response procedures</td>
<td>Distinguish an object or shape at a certain distance</td>
<td>Fulfills the eyesight standards for the merchant mariner credential applied for (see <a href="http://www.uscg.mil/nmc">www.uscg.mil/nmc</a> for more info)</td>
</tr>
<tr>
<td>React to audible alarms and instructions, emergency response procedures</td>
<td>Hear a specified decibel (dB) sound at a specified frequency</td>
<td>Fulfills the hearing standards for the merchant mariner credential applied for</td>
</tr>
<tr>
<td>Make verbal reports or call attention to suspicious or emergency conditions</td>
<td>Describe immediate surroundings and activities, and pronounce words clearly</td>
<td>Is capable of normal conversation</td>
</tr>
<tr>
<td>Participate in fire fighting activities</td>
<td>Be able to carry and handle fire hoses and fire extinguishers</td>
<td>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</td>
</tr>
<tr>
<td>Abandon ship</td>
<td>Use survival equipment</td>
<td>Has the agility, strength, and range of motion to put on a personal flotation device and exposure suit without assistance from another individual</td>
</tr>
</tbody>
</table>

### 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舍der 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.

CG-719K (01/14) Previous Editions Obsolete
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

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PRIVACY ACT STATEMENT


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.

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 National Maritime Center, 100 Forbes Drive, Martinsburg, WV 25404.
DEPARTMENT OF HOMELAND SECURITY  
U.S. Coast Guard  
APPLICATION FOR MERCHANT MARINER MEDICAL CERTIFICATE  
OMB No. 1825-0040  
Exp. Date: 01/31/2016

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  
City  
State  
Zip Code  
Primary Phone Number  
Alternate Phone Number  
E-mail Address  

Delivery/Mailing Address, if different (PO Box acceptable)  
Street Address  
City  
State  
Zip Code  
Other  

Application Type:  
Medical Certificate  
First Class Pilot  
I have a medical waiver:  
Yes  
No  
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 reenrolled 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)

<p>| | |</p>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Field of Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applicant must have a 100-degree horizontal field of vision.</td>
</tr>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>Abnormal</td>
</tr>
</tbody>
</table>

b. Color Vision (check one)

- □ 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 55dB 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/hmc/medical/default.asp) for further guidance. Report any additional information or comments in Section VII.

<table>
<thead>
<tr>
<th>Audimeter Threshold Value</th>
<th>500Hz</th>
<th>1,000Hz</th>
<th>2,000Hz</th>
<th>3,000Hz</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Ear (Unaided)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Ear (Unaided)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Ear (Aided)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Ear (Aided)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Speech Discrimination Test @ 65dB, if required by instruction (b) above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Ear (Unaided):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Left Ear (Unaided):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Right Ear (Aided):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Left Ear (Aided):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>

CG-719K (01/14) Applicant Name: (Last, First, Mi.)  Date of Birth: (MM/DD/YYYY)

Page 3 of 5
<table>
<thead>
<tr>
<th>Item</th>
<th>Additional Information (Please Print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Face, Neck, Scalp</td>
<td>Normal</td>
</tr>
<tr>
<td>2. Eyes/Pupils/EOM</td>
<td>Normal</td>
</tr>
<tr>
<td>3. Mouth and Throat</td>
<td>Normal</td>
</tr>
<tr>
<td>4. Ears/Drums</td>
<td>Normal</td>
</tr>
<tr>
<td>5. Lungs and Chest</td>
<td>Normal</td>
</tr>
<tr>
<td>6. Heart</td>
<td>Normal</td>
</tr>
<tr>
<td>7. Abdomen</td>
<td>Normal</td>
</tr>
<tr>
<td>8. Upper/Lower Extremities</td>
<td>Normal</td>
</tr>
<tr>
<td>9. Spine/Musculoskeletal</td>
<td>Normal</td>
</tr>
<tr>
<td>10. Skin</td>
<td>Normal</td>
</tr>
<tr>
<td>11. Lymphatic</td>
<td>Normal</td>
</tr>
<tr>
<td>12. Neurologic</td>
<td>Normal</td>
</tr>
<tr>
<td>13. Vascular System</td>
<td>Normal</td>
</tr>
<tr>
<td>14. Genitourinary System</td>
<td>Normal</td>
</tr>
<tr>
<td>15. General/Systemic</td>
<td>Normal</td>
</tr>
<tr>
<td>16. Hernia</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Missing Extremities/Digit</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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/mmc/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.

<table>
<thead>
<tr>
<th>Physical Ability Results</th>
<th>COMMENTS: (Please Print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Applicant has the physical strength, agility, and flexibility to perform all of the items listed in the instruction table.</td>
<td></td>
</tr>
<tr>
<td>[ ] Applicant does NOT have the physical strength, agility, and flexibility to perform all of the items listed in the instruction table.</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>License Number</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: __________________________ Date (MM/DD/YYYY) __________________________

MD/DO [ ] PA [ ] NP [ ]

Office Street Address: __________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Phone Number: __________________________

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) __________________________

CG-719K (01/14) Applicant Name: (Last, First, M.I.) __________________________ Date of Birth: (MM/DD/YYYY) __________________________

Previous Editions Obsolete Page 5 of 5
HEALTH ATTESTATION FORM
REQUIRED FOR ALL STUDENTS

STUDENT NAME: ________________________________

MUST BE SIGNED BY MEDICAL PRACTITIONER

_____ I find the applicant to be in good physical and mental health and able to meet the physical and emotional demands of participating in a full program of college study at SUNY Maritime.

_____ I find the applicant has the following medical condition/injury for which continuation of care is required which may adversely affect his/her ability to meet the physical and emotional demands of participating in a full program of college study at SUNY Maritime. Please explain below.

_________________________________________________________

Medical Practitioner Signature                          Date

Name of Medical Practitioner (Please Print)

Address:                                               Phone: (   )

City:                                                   State:  Fax: (   )

Place Medical Practitioner/Office STAMP Here:

MUST BE SIGNED BY STUDENT

My signature below attests that all information provided by me on the SUNY Maritime College Health Forms is complete and true to the best of my knowledge and that I have not knowingly omitted any material information relevant to this form.

Student Signature                          Date

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throgs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu
Medical Disqualifying Policy for USCG Licensing (MMC)

Required for REGIMENTAL Students Only

Dear SUNY Maritime Cadet:

If you are seeking a USCG 3rd Officers deck/engine/limited license (aka Merchant Mariner’s Credential -MMC) as part of your studies here at SUNY Maritime College you are REQUIRED to disclose and review your past and current medical history with SUNY Maritime College Health Services.

You may have a pre-existing medical/mental condition, take medication, and/or suffer an injury/illness during your enrollment that may preclude you from earning an USCG license.

There are a number of medical conditions that may require further review by the USCG if you are seeking an MMC. The USCG may grant a mariner a medical waiver with or without restrictions for certain physical and/mental conditions and medications. The USCG reviews each application on a case by case basis. In addition, they reserve the right to modify their medical requirements at any given point.

The medical condition and/or medications may not prevent you from attending classes at SUNY Maritime College; however, it may disqualify you from receiving a license. Only the USCG Medical Review Board, not SUNY Maritime College Health Services can determine if you are eligible for a medical waiver.

It is critically important and your responsibility as a Cadet to review your medical history with our College Physician Assistant. Furthermore, in the event that there are any changes to your medical history throughout your time at SUNY Maritime; such as, but not limited to, new medical conditions, surgeries, medications, etc., it is imperative and your responsibility to update your medical file with Health Services and provide appropriate medical documentation, regardless if the medical condition/illness/injury happened on campus.

If you have any questions regarding your medical history and potential to receive a USCG MMC, you are urged to contact Ms. Camenzuli, PA-C at 718-409-5424 or dcamenzuli@sunymaritime.edu.

By signing below I acknowledge I fully understand that I may be asked to provide further medical documentation when applying for a USCG license/MMC. In addition, I acknowledge that there are certain medical conditions that can be disqualifying and may prevent me from getting a USCG License/MMC. I acknowledge that I will disclose and review my medical history with Health Services and provide appropriate medical documentation throughout my time at SUNY Maritime College.

Student Name (please print): ___________________________ ID#: ___________________________

Student signature: ___________________________ Date: ___________________________

Parent/Guardian Name (if under 18) (please print): ___________________________

Parent/Guardian Signature: ___________________________ Date: ___________________________

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu
Medical Clearance Form for Indoctrination 2017
REQUIRED FOR REGIMENTAL STUDENTS ONLY

Student Name: __________________________ Date of Birth: ________________

All cadets must receive appropriate medical screening and clearance prior to participating in the SUNY Maritime Indoctrination Program and Physical Readiness Test (PRT). The Physical Readiness Test is a standard fitness test consisting of push-ups, curl-ups (sit-ups) and a 1.5 mile run. Please see the table below for the passing PRT standards.

<table>
<thead>
<tr>
<th>Physical Readiness Test Breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete 1.5 Mile Run in 13:00 (males) or 15:30 (females)</td>
</tr>
<tr>
<td>Swim 100 meters without a rest period (male and female)</td>
</tr>
<tr>
<td>Tread water for 5 minutes (male and female)</td>
</tr>
<tr>
<td>Is able, without assistance, to intermittently stand on feet for up to 4 hours with minimal rest periods (male and female)</td>
</tr>
<tr>
<td>Is able, without assistance, to climb up and down 4 flights of vertical ladders and stairways without a rest period (male and female)</td>
</tr>
<tr>
<td>Lift 40 lbs overhead (male and female)</td>
</tr>
<tr>
<td>Complete 50 sit-ups (male and female)</td>
</tr>
<tr>
<td>Complete push-ups: 40 (males) or 15 (females)</td>
</tr>
</tbody>
</table>

Upon completion of a thorough history and physical examination, I find the applicant to be in good physical health, without any injury, illness, or recovering from a surgical or medical procedure, which will prevent them from participating in a Physical Readiness Test.

My signature below attests that I find the applicant to be medically cleared and able to participate in the Indoctrination Program and Physical Readiness Test.

Medical Practitioner Signature __________________________ Date ________________

Name of Medical Practitioner (Please Print) __________________________

Address: __________________________ Phone: ________________ Fax: ________________

Place Medical Practitioner/Office STAMP Here:

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.5424 | www.sunymaritime.edu
SICKLE CELL TRAIT POLICY

Required for ATHLETES only.

About Sickle Cell Trait:

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in red blood cells.
- Although sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen in the tissue) may cause red blood cells to change shape from a normal disc shape to a crescent or “sickle” shape. Such cells can accumulate in the bloodstream and “logjam” blood vessels, blocking circulation to muscles, as well as the heart, leading to a collapse from the decreased circulation of blood.

SUNY Maritime College requires that ALL STUDENT-ATHLETES be tested for sickle cell trait status and show proof of a prior test and provide documented results to SUNY Maritime.

Proof of a prior test must be supplied in the form of:

1. A lab report with the results of a Hemoglobin solubility test or Hemoglobin electrophoresis test (a total Hemoglobin count will not be accepted)

2. A physician’s letter stating the date of the test and the results. Letter must be on physician’s letterhead with a valid signature, NOT a stamp. Notes on physician’s prescription pads WILL NOT be accepted.

NOTE: Most individuals are tested for the Sickle Cell Trait as a newborn. The student may contact their pediatrician for more details. The student may also find information at their state’s Board of Health or find their state’s Newborn Screening Center at http://genes-r-us.uthscsa.edu/resources/consumer/statemap.htm

_________________________________        ____________________________________________
Student’s Signature                     Parent/Guardian Signature (if under 18 years)

_____________________________________
Date
Athletics Medical Clearance Form
Academic Year 2016-2017

Student Name: Last________________ First________________
DOB: ____________________________ Cell Phone: ____________________
Email: ____________________________

Anticipated Sports Participation: (Circle all that apply)
Football Sailing Baseball
Men's Soccer Rowing Women's Lacrosse
Women's Soccer Cross Country Men's Lacrosse
Women's Volleyball Men's Basketball Swimming and Diving

A medical clearance shall be submitted (valid for one calendar year), signed by a medical doctor, stating that the Student has been physically examined and is deemed to be in sufficiently good health and fitness so that the student may fully participate in Sports.

For Physician's Use

I certify that I examined the above stated student and found him/her fit to participate in sports as follows: ☐ Full Clearance ☐ Limited due to: ________________________________

Past injuries and physical conditions that are of particular note and/or concern:

____________________________________________________________________

____________________________________________________________________

This medical clearance shall be valid for one year from the date signed below.

Date: _________________ Physician Signature: ____________________________