MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

Fall 2016 New Incoming Student Health Requirements – Check List

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**

- ☐ **Physical Fitness Assessment and Medical Clearance Form for Indoctrination**

* While it is not required, it is strongly encouraged that prior to arrival, Regimental students secure a Yellow Fever Vaccine, a Typhoid Fever Vaccine, show proof of Blood Type (with Rh factor), G6PD Blood Test results and Sickle Cell Trait Blood test results. The above **will** be needed to secure certain industry internships.

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 6, 2016

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 bravenel@sunymaritime.edu

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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)

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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 (Rubeola):
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:___/___/___

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

IMMUNIZATION RECORDS FORM

REQUIRED FOR ALL CIVILIAN AND REGIMENTAL STUDENTS

STUDENT NAME: _____

Tetanus-Diphtheria (Minimum 3 doses required for all students):
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: _____

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)*** ☐
Street Address | E-mail 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	Field of Vision
Right: 20/	Right: 20/	*This applicant must have a 100-degree horizontal field of vision*
Left: 20/	Left: 20/	☐ 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/hq/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

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)

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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: _____

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

Physical Fitness Assessment and Medical Clearance Form for Indoctrination

REQUIRED FOR REGIMENTAL STUDENTS

Student Name: _____ **Date of Birth:** _____

Upon completion of a thorough history and physical examination:

☐ Please check **YES** if the applicant is both medically and physically cleared to participate in each of the following physical activities.

☐ Please check **NO** if the applicant is not medically and or physically cleared to participate in each of the following physical activities. **Please explain why.**

The Medical Practitioner MUST INITIAL every item.

Physical Activity	YES	NO: Please explain why.	Medical Practitioner Initials
Is able to complete 1.5 Mile Run in 13:00 (males) or 15:30 (females)			
Is able to swim 100 meters without a rest period (male and female)			
Is able to tread water for 5 minutes (male and female)			
Is able, without assistance, to intermittently stand on feet for up to 4 hours with minimal rest periods (male and female)			
Is able, without assistance, to climb up and down 4 flights of vertical ladders and stairways without a rest period (male and female)			
Is able to lift 40 lbs overhead (male and female)			
Is able to complete 50 sit-ups (male and female)			
Is able to complete push-ups: 40 (males) or 15 (females)			

MUST BE SIGNED BY MEDICAL PRACTITIONER

_____ My signature below attests that I find the applicant to be in good physical health, medically cleared and fully capable of participating in and meeting the above physical requirements.

_____ My signature below attests that I find the applicant unable to participate in the above physical activities and/ unable to meet the above physical requirements.

Medical Practitioner Signature Date

Name of Medical Practitioner (Please Print)

Address: Phone: Fax:

Place Medical Practitioner/Office STAMP Here:

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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 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: _____

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

IMMUNIZATION RECORDS FORM

REQUIRED FOR ALL STUDENTS

STUDENT NAME: _____

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