MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

REQUIRED FOR ALL NEW INCOMING 2025 - 2026 STUDENTS

STUDENT NAME: _____ M#:_____

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.

Submit your Health Forms to: https://sunymaritime.studenthealthportal.com/Forms

Please allow ten days for our Health Services team to review your health forms. We will reach out to you via your SUNY Maritime email once we have finished our review.

REQUIRED FOR ALL NEW 2025 - 2026 INCOMING STUDENTS

1. **STUDENT INFORMATION EMERGENCY PAGE**
2. **HEALTH ATTESTATION FORM**
3. **IMMUNIZATION RECORDS**
4. **MENINGITIS RESPONSE FORM**
5. **PHYSICAL EXAMINATION FORM FOR ALL STUDENTS REGARDLESS OF MAJOR**

REQUIRED FOR ALL NEW REGIMENTAL INCOMING 2025 – 2026 STUDENTS

1. **COMPLETED 719K (See PowerPoint for Instructions), Blank 719K will be included in this packet!**
2. **Page 10 for 719K is the last page in this packet, please attach to you 719k Form before you submit through the portal.**

All medical paperwork is to be submitted via portal only: 2025 - 2026 Incoming Health Forms

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

REQUIRED FOR ALL NEW INCOMING 2025 -2026 STUDENTS

STUDENT NAME: _____ **M#:** _____

STUDENT INFORMATION

Name: _____
Last First Middle

Address: _____
Street City State Zip

Birth date:_____/_____/_____ **Age**:_____ **Female**: _____ **Male:** _____ **Other:**_____

E-mail: _____ **Preferred Phone Number:** ( ) _____

Please circle entering year: Fall 2025 Spring 2026

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)

REQUIRED FOR ALL NEW INCOMING 2025- 2026 STUDENTS

STUDENT NAME: _____ **M#:** _____

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 isrequired 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

REQUIRED FOR ALL NEW INCOMING 2025-2026 STUDENTS

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

STUDENT NAME: _____ **M#:** _____ **Please**

Please submit a copy of your complete immunization records.
Please be sure that you have the mandatory vaccines listed below.
COVID 19 vaccine is optional!

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:___/___/_____

Tetanus-Diphtheria: (Minimum 3 doses required for all students – **dose MUST be within 10 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: _____

Covid _ 19: Vaccine Name_____1st Dose Date / / 2nd Dose Date_ / /_____Booster Date_ / /

Covid is a recommended vaccine, not required.

REQUIRED FOR ALL NEW INCOMING 2025-2026 STUDENTS

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

STUDENT NAME: _____ **M#:** _____

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 more than 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

REQUIRED FOR INCOMING REGIMENTAL CADETS 2025 -2026

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu

STUDENT NAME: _____ **M#:** _____

SUNY Maritime College is committed to ensuring that students enrolled in the license program meet the U.S Coast Guard medical and physical ability requirements to qualify for U.S. Coast Guard licensure.

All incoming students are required to complete a physical examination upon admission to SUNY Maritime College.

The U.S. Coast Guard has set forth a non-exhaustive list of medical conditions, medications, and physical abilities that may be subject to further review. Cadets with these medical conditions and/or physical limitations who do not meet the U.S Coast Guard's medical and physical ability requirements may be denied the ability to qualify for U.S. Coast Guard licensure or they may be granted a license with restrictions and/or limitations. There are also medical conditions and limitations that are not listed which would render one ineligible to receive a license. Please note that the U.S. Coast Guard evaluates each applicant individually and the final determination regarding license eligibility lies with the U.S. Coast Guard, notSUNY Maritime College.

All cadets enrolled in the license program must agree to adhere to the following policies to ensure that the individual meets the U.S. Coast Guard medical and physical requirements:

1. Submit the application for medical certificate (CG-719K) to the Director of Licensing within the first 9 months of enrollment.

2. Continue to meet the medical and physical ability requirements throughout enrollment at SUNY Maritime College.

3. Inform Maritime Health Services of any change in health status once enrolled, including but not limited to new diagnosis, change of medication, surgery or hospitalization.
    a. Failure to provide current, accurate information may jeopardize continued enrollment in the license program.

4. In accordance with this policy, if a cadet has a medical or physical condition that disqualifies the individual from meeting the requirements, he/she shall be transferred to a non-license program until such individual meets the medical and physical ability requirements.

You are encouraged to contact Dr. Wilkow (Director, Student Health Services) at bwilkow@sunymaritime.edu or healthservices@sunymaritime.edu at (718) 409 -7347 with any questions regarding the U.S. Coast Guard medical and - physical ability requirements.

My signature below attests that I will fully adhere to the SUNY Maritime College medical policies for U.S. Coast Guard licensure.

Student Name (please print): ID#:

Student Signature: Date: _____

Parent/Guardian Name: (please print):

Parent/Guardian Signature: Date:

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

REQUIRED FOR INCOMING REGIMENTAL CADETS 2025 -2026

Informed Consent Form for Physical Activity

Cadets Name _____ ID# _____

I understand that INDOCRINATION (INDOC) is a physical program which includes exercises to build the cardiorespiratory system (heart and lungs), the musculoskeletal system (muscle endurance and strength, and flexibility), and to improve body composition (decrease of body fat in individuals needing to lose fat, with an increase in weight of muscle and bone). Exercise may include, but not limited to aerobic activities (walking, running, rowing, swimming, and other aerobic activities), callisthenic exercises, and endurance and flexibility exercises to improve joint range of motion.

Description of Potential Risks:
I understand that the potential for injury exists with each of the physical activities performed. I further understand that I am going to partake in the INDOC program before my personal medical practitioner has cleared me to do so.

I understand that SUNY Maritime College, its staff, and faculty shall not be liable for any damages arising from personal injuries sustained by me (Cadet) during the INDOC program.

I hereby fully and forever release and discharge SUNY Maritime College and its staff and faculty from all claims, demands, damages, rights of action, present and future therein.

I understand and warrant, release and agree that I am in good physical condition and that I have no disabilities, impairments or ailments preventing me from engaging in active or passive exercises that will be detrimental to my being.

I state that I have had a recent physical exam and shall present said document to the Department of Health Services by 9Sept2020.

Cadet Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

REQUIRED FOR INCOMING REGIMENTAL CADETS 2025 -2026

MEDICAL CLEARANCE FOR PARTICIPATION IN ORIENTATION

Student Name _____ DOB _____

The above-named student is cleared to fully participate in the physical demands of orientation at SUNY Maritime College without restrictions or concerns for their safety and well-being. Specifically, they are cleared for the following:

- Running and sprinting
- Long periods of marching in formation
- Physical training, including push-ups and sit-ups, and pull ups.
- Overhead arm activities such as throwing, catching, climbing.
- Swimming, treading water, flipping a life raft, and donning a water survival suit.
- Sports, including water polo, ultimate frisbee, softball, dodgeball, basketball
- Pulling heavy objects
- Participation in physical activities in hot and humid conditions

Signature of medical care provider: _____ Date: _____

Office Stamp:

NOTE This does not guarantee requirements for the license programs

Signature of student: _____ Date: _____

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

REQUIRED FOR INCOMING REGIMENTAL CADETS 2025 -2026

History & Physical Exam

Student Name		**DOB**	

MEDICATIONS	**ALLERGIES**

CARDIAC SCREENING & Exam	**YES**	**NO**
Is there a history of heart disease, including murmur?		
Has the patient ever had an abnormal EKG or anormal echocardiogram?		
Is there a history of lightheadedness, fainting, or chest pain during exertion?		
Does the patient report any palpitations or irregular heart rhythm?		
Is there a family history of sudden cardiac death or cardiac event before the age of 45?		
Is there a history of moderate to severe COVID-19?		
If history of moderate to severe COVID-19 is there post-cardiac clearance?		

Rate		**Rhythm**	***REGULAR*** ***IRREGULAR***	**Murmur Description**	

MEDICAL HISTORY & PHYSICAL EXAMINATION
Describe any significant health history including mental health. Note physical exam abnormalities and list restrictions and /or limitations.

Please note: No accommodations can be made for our physically demanding orientation program.

SIGNATURE	

Signature of MD, DO, PA, NP **Date of Exam**

SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

OMB No. 1625-0040
Exp. Date: 03/31/2021

APPLICATION FOR MEDICAL CERTIFICATE (FORM CG-719K)

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

Who must submit this form?

1. Applicants seeking a Medical Certificate are required to complete this form and submit all 10 pages, including instructions, to the U.S. Coast Guard. Guidance for completion of this form can be found at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf.
2. Mariners applying for or holding a merchant mariner credential **with only an entry-level endorsement** who serve on a vessel not subject to the International Convention on Standards of Training, Certification and Watchkeeping (STCW) but who request a **medical certificate that satisfies the Maritime Labor Convention (MLC), AND want to be qualified for lookout duties** should submit this form. Sections III (Medical Conditions), IV (Medications) and V (Physical Examination) of the CG 719K **DO NOT** have to be completed. The medical certificate will be restricted to entry-level only.
3. The Coast Guard will not accept an application for a medical certificate without a reference number or a Merchant Mariner Credential (MMC).

Who may conduct this exam?

1. All exams, tests and demonstrations must be performed, witnessed or reviewed by a physician, physician assistant, or nurse practitioner licensed by a state in the U.S., a U.S. possession, or a U.S. territory.
2. Medical examinations for U.S. Registered Pilots must be conducted by a licensed medical doctor.

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

- **Legal Name** - Enter complete legal name.
- **Date of Birth** - If applicant is under 18 years of age, attach a notarized statement, signed by a parent or guardian, authorizing the Coast Guard to issue a Medical Certificate.
- **Mariner Reference Number or Social Security Number** - If you have held a Coast Guard credential in the past, enter your reference number.
- **Gender** - Enter your 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 certificates 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** - *(Optional)* If provided, the National Maritime Center *(NMC)* may attempt to contact you via e-mail. You will receive automated updates regarding the status of your application.
- **Other** - Please provide additional means of communicating with you *(satellite phone, work phone, etc.) (optional)*.
- **Endorsement held or sought** - **Applicants should select all options that apply.** If nothing is selected, the Coast Guard will not accept the application.

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

Refer to instructions provided in this section. The **Medical Practitioner** should initial and date at the bottom of each page of the application, where indicated.

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

III(a) **Applicants** must report their relevant medical conditions to the best of their knowledge. Applicants should check YES if: 1) they have had a previous diagnosis, or treatment for the condition by a health care provider; 2) they are currently under treatment or observation for the condition; or 3) the condition is present, regardless of treatment status.

III(b) The **Medical Practitioner** must review and discuss all conditions reported by the applicant in Section III(a). The **Medical Practitioner's** discussion should include, at a minimum, the name of the condition, approximate date of diagnosis, treatment, current status of the condition, limitations of the condition, and any additional information as appropriate. Recommended supporting documentation and testing for conditions that are subject to further review are contained in the **Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials** which can be found at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf. Medical practitioners should be familiar with the guidelines contained within this document. If the **Medical Practitioner** discovers a condition not reported by the applicant, they must check **YES** in the appropriate block in III(a) and provide information on the condition, as requested, in Section III(b). For conditions that were **Previously Reported**, the Medical Practitioner need only discuss the interval history and current status of the condition. 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. The **Medical Practitioner** should **initial and date at the bottom of each page** of the application, where indicated.

☐ **MEDICAL PRACTITIONER INITIALS:** _____ ☐ **DATE:** _____

Print Applicant Name: *(Last, First, MI.)* _____ Date of Birth: *(MM/DD/YYYY)* _____

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

Applicants - **Refer to instructions provided in this section.**

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. The **Medical Practitioner** should **initial and date at the bottom of each page** of the application, where indicated.

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

The Medical Practitioner must document the results of the physical examination in this section. The **Medical Practitioner** should **initial and date at the bottom of each page** of the application, where indicated.

Section VI: (Vision) and VII: (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 the vision and hearing examinations. These may be performed by qualified office staff or referred to other qualified practitioners such as audiologists or optometrists; however, the results must be reviewed by the **Medical Practitioner**.

The **Medical Practitioner** should **initial and date at the bottom of each page** of the application, where indicated.

Additional guidance can be found at: https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf.

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

Refer to the table and instructions provided in this section. The **Medical Practitioner** should initial and date at the bottom of each page of the application, where indicated.

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

a. **Applicant Proof of Identity Provided** - Applicants shall present acceptable proof of identity to the **Medical Practitioner** conducting examinations. Proof of identity shall consist of one current form of valid government-issued photo identification. Examples of acceptable proof of identity include 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 Credential, or Transportation Worker Identification Credential.

b. **Certification recommendation** - The **Medical Practitioner** must ensure a complete history and physical are conducted. The practitioner should address the listed questions and make a certification recommendation. The Coast Guard retains final authority for the issuance of the medical certificate.

c. **Assessment** - The **Medical Practitioner** should provide answer to statement 1 or 2, as appropriate for the credential sought. Option 2 is for mariner applicants who are only seeking an MLC-compliant, entry-level medical certificate.

d. **Discussion** - The **Medical Practitioner** should discuss any conditions or issues of concern.

e. **Medical Practitioner** (Attestation and Information) - Attests that the general medical examination, vision and hearing tests, and demonstration of physical ability, as appropriate, have been performed to the satisfaction of the **Medical Practitioner**. The **Medical Practitioner** must sign and date the attestation 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 their knowledge and that the **Medical Practitioner** has not knowingly omitted or falsified any material information relevant to this form.

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

Applicant certifies that the information provided is true and correct.

Section XI: Applicant Consent *(optional)* - To be completed by the Applicant

Third Party Authorization - If you want the NMC to be able to discuss, release, or receive information/documents regarding your medical certificate application with a third party *(spouse, employer, school, union, etc.)* you must provide specific guidance to the NMC regarding what issues we may discuss and with whom. You may allow release of all information to certain individuals or entities. If you limit the release of certain information you must be specific by making a selection on the application or by attaching additional documentation. For each selection made, ensure the Name of the Organization or Third Party, Organization Point of Contact *(if applicable)*, Address and Phone Number is completed. If you wish to provide multiple Third Party Authorizations, attach additional pages as needed. A sample may be found on the **NMC website:** https://www.uscg.mil/nmc/credentials/forms/3rd_party_authorization_med_cert.pdf. **Please sign and date for** each type of consent that you wish to authorize.

a. Consent for Medical Practitioner to Release Information to the Coast Guard

b. Consent for Coast Guard to Release Information to a Third Party

c. Consent for Third Party to Act on your Behalf

☐ **MEDICAL PRACTITIONER INITIALS:**_____ ☐ **DATE:**_____

Print Applicant Name:*(Last, First, MI.)* _____ Date of Birth: *(MM/DD/YYYY)* _____

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

OMB No. 1625-0040
Exp. Date: 03/31/2021

APPLICATION FOR MEDICAL CERTIFCATE (FORM CG-719K)

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)

Mariner Reference Number or Social Security Number | Gender: ☐ Male ☐ Female ☐ | Date of Birth (MM/DD/YYYY)

Please indicate best method(s) of contact by checking the appropriate box(es).

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

City | State | Zip Code | Alternate Phone Number ☐

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

City | State | Zip Code | Other ☐

Endorsement Held or Sought *(Check all that apply or the Coast Guard will not accept the application):*

☐ Deck ☐ Engine ☐ Food Handler ☐ STCW ☐ Entry-level with lookout duties

☐ U.S. Registered Pilot (Great Lakes Pilotage) ☐ First-Class Pilot or those Serving as Pilot (Federal Pilotage/46 CFR 15.812)

☐ **Other (Please explain):** _____

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

1. Food Handlers must obtain a statement from the **Medical Practitioner** that attests that they are free of communicable diseases that pose a direct threat to the health or safety of other individuals in the workplace. For applicants who have requested Food Handler Certification *(Food Handler box is checked in Section I, above)*, the **Medical Practitioner** may provide the attestation by answering Yes or No to the question in bold below.
2. **Communicable disease** is defined in 46 CFR 10.107 as any disease capable of being transmitted from one person to another directly, by contact with excreta or other discharges from the body; or indirectly, via substances or inanimate objects contaminated with excreta or other discharges from an infected person.
3. The **Medical Practitioner** need not perform any additional 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. Circumstances that the Medical Practitioner should consider when certifying an applicant include, but are not limited to, the following:
   a. Whether the applicant reports they have been diagnosed with, or exposed to an illness due to organisms including, but not limited to, Salmonella Typhi, Shigella Spp., Shiga-toxin-producing Escherichia coli, or Hepatitis A virus within the past month.
   b. Whether 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. Whether 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.

Is the applicant free from communicable disease? ☐ Yes ☐ No ☐ N/A

☐ **MEDICAL PRACTITIONER INITIALS:** _____ ☐ **DATE:** _____

Print Applicant Name: *(Last, First, MI.)* _____ Date of Birth: *(MM/DD/YYYY)* _____

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

I have a **medical waiver (MW)**: ☐ Yes ☐ No If **YES**, provide a copy to the Medical Practitioner, and mark the **MW** box below.

To the best of your knowledge, have you ever had, required treatment for, or do you presently have any of the following conditions? If no, please mark the **NO** box below. If yes, please mark the **YES** box below, and if **previously reported (PR)**, mark the PR box below.

ITEM	YES	NO	PR	MW	CONDITIONS
1.					1. Blurry vision, poor night vision, eye disease or injury, eye surgery, abnormal color vision, cataracts or glaucoma
2.					2. Hearing loss, hearing aid, ear surgery, facial deformities, open tracheostomy or frequent severe nose bleeds
3.					3. High or low blood pressure
4.					4. Heart or vascular disease of any kind, to include angina, chest pain, irregular heart beat, heart valve problem/ replacement, heart attack/myocardial infarction, or congestive heart failure
5.					5. Heart surgery and/or implanted devices (for example, angioplasty, stent, pacemaker, or defibrillator)
6.					6. Lung disease of any type (for example, asthma, emphysema, or chronic obstructive pulmonary disease (COPD))
7.					7. Any blood disorder (for example, anemia, hemophilia, blood clots, or polycythemia)
8.					8. Diabetes, glucose intolerance, or sugar in urine
9.					9. Thyroid problem requiring treatment or hospitalization
10.					10. Stomach, liver or intestinal disorder requiring ongoing medical care/medication, or causing significant bleeding or debilitating pain; history of hepatitis or jaundice
11.					11. Kidney problems/stones or blood in urine
12.					12. Any other urinary or bladder problems not listed above requiring treatment or hospitalization
13.					13. Skin disorders requiring medical treatment, such as cancer, tumors, scleroderma or lupus
14.					14. Severe allergies or allergic reactions to any substance, medication, food, or insect stings
15.					15. Communicable disease or chronic infectious diseases such as tuberculosis, HIV/AIDS, or hepatitis
16.					16. Any sleep problems (for example, obstructive sleep apnea, restless leg syndrome, narcolepsy, shift work sleep disorder, or insomnia)
17.					17. Epilepsy, fits, or seizures
18.					18. History of serious head injury, loss of consciousness or memory loss
19.					19. Frequent or severe headaches
20.					20. Dizziness/fainting spells/balance problems
21.					21. Frequent motion sickness requiring medication
22.					22. Stroke or Transient Ischemic Attack (TIA), brain tumor or other brain disorder
23.					23. Any neurologic disorder or nerve problems including numbness and/or paralysis, not listed above
24.					24. Attention deficit disorder with or without hyperactivity
25.					25. Anxiety, depression, bipolar disorder, adjustment disorder, PTSD, or schizophrenia
26.					26. Suicide attempt or thought(s) of suicide (Suicidal Ideation)
27.					27. Evaluation, treatment, or hospitalization for alcohol or substance use, abuse, addiction, or dependence (including illegal drugs, prescription medications, or other substances)
28.					28. Any other psychiatric disorder, mental health evaluation/treatment/hospitalization
29.					29. Back, neck or joint problems that impair movement or cause debilitating pain
30.					30. Amputation, prosthesis, or use of ambulatory devices (for example, cane, walker, or braces)
31.					31. Injuries, fractures or recurrent dislocations causing impairment or limitation of motion of any joint
32.					32. Have you ever been signed off a vessel as sick or repatriated for medical reasons within the last six years?
33.					33. Any diseases, surgeries, cancers, illnesses, or disabilities not listed on this form?
34.					34. Any hospital admissions within the last six years not listed elsewhere in this Section?

☐ **MEDICAL PRACTITIONER INITIALS:** _____ ☐ **DATE:** _____

Print Applicant Name: *(Last, First, MI.)* ______ Date of Birth: *(MM/DD/YYYY)* ______

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

Instructions: For each item marked **YES** in Section III(a), the **Medical Practitioner** must provide the information requested IN THE BLOCKS below. For each condition marked **Previously Reported (PR)**, the provider need only discuss the interval history and current status of the condition.

For conditions with a **Medical Waiver (MW)** review the applicant's waiver letter and attach all waiver reporting requirements.

Please **attach appropriate evaluation data** for conditions that are subject to further review. Information on conditions that are subject to further review and the recommended evaluation data can be found in the Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials, located at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf.

Indicate whether additional information has been attached by marking the **ATTACHED** box. **Additional sheets may be added**, if needed to complete this section *(include applicant name and date of birth on each additional sheet)*.

Item # ______ **Date of onset or diagnosis** (mm/dd/yyyy) ______ **Attached** ☐

Condition	**Treatment**
Status	**Limitations**

Item # ______ **Date of onset or diagnosis** (mm/dd/yyyy) ______ **Attached** ☐

Condition	**Treatment**
Status	**Limitations**

Item # ______ **Date of onset or diagnosis** (mm/dd/yyyy) ______ **Attached** ☐

Condition	**Treatment**
Status	**Limitations**

Item # ______ **Date of onset or diagnosis** (mm/dd/yyyy) ______ **Attached** ☐

Condition	**Treatment**
Status	**Limitations**

Item # ______ **Date of onset or diagnosis** (mm/dd/yyyy) ______ **Attached** ☐

Condition	**Treatment**
Status	**Limitations**

☐ **MEDICAL PRACTITIONER INITIALS:** ______ ☐ **DATE:** ______

Print Applicant Name: *(Last, First, MI.)* _____ Date of Birth: *(MM/DD/YYYY)* _____

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

Do you currently use any medication (prescription or nonprescription)? ☐ Yes ☐ No **If YES,** provide the information requested in the blocks below.

Applicants Must Report

1. All medications (Prescription or Nonprescription), dietary supplements, and vitamins; that were filled, or refilled, and/or taken within 30 days prior to the date the applicant signs the CG-719K; **and**
2. All medications (Prescription or Nonprescription), dietary supplements, and vitamins that were used for a period of 30 or more days within the last 90 days prior to the date the applicant signs the CG-719K.

Medical Practitioner

1. Medical Practitioner must verify applicants medications and information listed in the table below.
2. Medical Practitioner comments should include the approximate length of time the applicant has taken the medication and address the presence or absence of any side effects.

Additional guidance on medications, including those that may be considered disqualifying, can be found at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf.

Additional sheets may be attached by the Applicant and/or Medical Practitioner if needed to complete this section. *(Include applicant name and date of birth on each additional sheet and check the box indicated on the right)* **ATTACHED** ☐

MEDICATION	DOSE	FREQUENCY	CONDITION	MEDICAL PRACTITIONER COMMENTS *(Duration of Use/Side Effects)*

REPORT OF MEDICAL EXAMINATION

Section V: Physical Examination - Items 1-17 must be performed and completed by the Medical Practitioner.

Height *(inches only)*: _____ Weight *(lbs)*: _____ Pulse Resting: _____ Blood Pressure: _____ Body Mass Index *(BMI)*: *(For BMI > 40 refer to Section VIII)* _____

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

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

Additional Medical Comments (Please Print)

☐ **MEDICAL PRACTITIONER INITIALS:** _____ ☐ **DATE:** _____

Print Applicant Name: *(Last, First, MI.)* _____ Date of Birth: *(MM/DD/YYYY)* _____

Section VI: Vision - Must be performed by the **Medical Practitioner**, their medical staff or other qualified practitioner. Results must be reviewed by the **Medical Practitioner**. Additional guidance can be found at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf.

a. Visual Acuity

Distance Vision, Uncorrected: If correction required, Distance Vision Correctable To:		Field of Vision
Right: 20/ _____	Right: 20/ _____	☐ Normal (the applicant's horizontal field of vision is greater than or equal to 100 degrees).
Left: 20/ _____	Left: 20/ _____	☐ Abnormal

b. Color Vision: The **Medical Practitioner** should assess the applicant's color vision sense using one of the following testing methodologies. The **Medical Practitioner** must indicate which test was utilized, and the **number of errors** obtained. In order to meet the standard, the applicant must demonstrate satisfactory color sense without the use of color enhancing lenses.

- ☐ 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
- ☐ 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 (2nd Edition) pseudoisochromatic 15 plate test (6 or less errors)

Alternative Testing *(attach evaluation/test results)*:
- ☐ Farnsworth D-15 Hue Test *(Engineer/radio officer/tankerman/MODU only)*
- ☐ Formal ophthalmology/optometry color vision evaluation
- ☐ Other alternative test acceptable to the Coast Guard

Color Vision Testing Results:

☐ Passed ☐ Failed Number of Errors: _____

Section VII: Hearing - Must be performed by the **Medical Practitioner**, their medical staff or other qualified practitioner. Results must be reviewed by the **Medical Practitioner**.

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 which can be found at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf for further guidance. Report any additional information or comments in Section IX.

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): _____ %

☐ **MEDICAL PRACTITIONER INITIALS:** _____ ☐ **DATE:** _____

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SUNY Maritime College Health Services
6 Pennyfield Avenue, Throggs Neck, NY 10465 | 718.409.7347 | www.sunymaritime.edu

Print Applicant Name: *(Last, First, MI.)* _____ Date of Birth: *(MM/DD/YYYY)* _____

Section VIII: 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*	*The Examiner Should Be Satisfied That The Applicant:*
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
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
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

1. The **Medical Practitioner** should indicate whether the applicant can meet the guidelines listed in the table above. If the **Medical Practitioner** doubts the applicant's ability to meet the guidelines contained within this table, and for all applicants with a Body Mass Index (BMI) of 40 or higher, the **practitioner** should require that the applicant demonstrate the ability to meet the guidelines contained within this table. 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 themselves 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 not all medical practitioners will 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 which can be found at https://www.uscg.mil/hq/cg5/nvic/pdf/2008/NVIC_04-08.pdf.
4. If the applicant is unable to perform all of the functions listed in the table above, 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 physical ability table. ☐ Applicant does **NOT** have the physical strength, agility, and flexibility to perform all of the items listed in the physical ability table.

COMMENTS: *(Please Print)* _____

☐ **MEDICAL PRACTITIONER INITIALS:** _____ ☐ **DATE:** _____

Print Applicant Name: *(Last, First, MI.)* | Date of Birth: *(MM/DD/YYYY)*

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

a. Applicant proof of identity provided: ☐ Yes ☐ No b. Certification recommendation: ☐ Recommended ☐ Not Recommended ☐ Needs Further Review

c. **Assessment:** 1. Preliminary screening indicates that the applicant is not at high risk of having a condition(s) that poses a significant risk of sudden incapacitation or debilitating complication, to include, uncontrolled obstructive sleep apnea, diabetes mellitus or coronary artery disease: ☐ Yes ☐ No ☐ Needs Further Review

OR,

2. *(Entry-level, only)* - To the best of my knowledge, mariner applicant is free from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board. ☐ Yes ☐ No ☐ Needs Further Review

d. **Discussion: Please discuss any conditions subject to further review identified in Section III(b) or any other concerns. Please print or type.**

e. Medical Practitioner: My signature attests, subject to criminal prosecution under 18 USC § 1001, that all information reported by me is true and correct to the best of my knowledge and that I have 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) | Phone Number | MD ☐ DO ☐ PA ☐ NP ☐

Office Street Address

City | State | Zip Code

(Place office address stamp here)

Section X: Application 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 Notice that accompanies this form.

Signature of Applicant | Date (MM/DD/YYYY)

PRIVACY NOTICE

Authority: 14 U.S.C. 632; 46 U.S.C. 2103, 7101, 7302, 7502, 46 C.F.R. 10.301

Purpose: The information is collected by the Coast Guard to determine whether an applicant meets the regulatory standards for issuance of a U.S. Merchant Mariner Credential (MMC). The Coast Guard evaluates an applicant's qualifications to determine compliance with the national and international requirements for issuance of the MMC, any endorsement within the MMC, and medical certificate.

Routine Uses: The information is used by authorized Coast Guard personnel who have a need for the record to determine whether an applicant is a safe and suitable person and qualifies for the MMC, any endorsement within the MMC, and medical certificate. In addition, the Coast Guard uses this information to maintain and update records of merchant mariner documentation transactions. 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 the non-issuance of the MMC, any endorsement within the MMC, and medical certificate.

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 Chief, Office of Merchant Mariner Credentialing, 2703 Martin Luther King, Jr. Ave, S.E., STOP 7509, Washington, D.C., 20593-7509.

MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

Print Applicant Name: *(Last, First, MI.)*		Date of Birth: *(MM/DD/YYYY)*	

Section XI: *(Optional)* Applicant Consent - To be completed by the Applicant **Declined** ☐

a. CONSENT FOR MEDICAL PRACTITIONER TO RELEASE INFORMATION TO THE COAST GUARD:

My signature below authorizes the Medical Practitioner, who has signed the certification on page 9 of this form, to release to, or discuss with authorized Coast Guard personnel, any pertinent information in his/her possession regarding any physical or medical condition that may require review by the Coast Guard prior to determining whether the Coast Guard should issue a merchant mariner medical certificate.

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

I have read and understand the following statement about my rights:

- ▶ I may revoke this authorization at any time prior to its expiration date by notifying the verifying medical practitioner in writing, but the revocation will not have any effect on any actions taken before they received the notification.
- ▶ Upon request, I may see or copy the information described in this release.
- ▶ I am not required to sign this release to receive my medical evaluation.

Signature of Applicant _____ Date (MM/DD/YYYY) _____

b. CONSENT FOR COAST GUARD TO RELEASE INFORMATION TO A THIRD PARTY:

My signature authorizes the Coast Guard to share my medical information with the third party indicated below. I understand that I may revoke this authorization at any time prior to its expiration date by notifying the Coast Guard in writing.

Please provide the Name of the Organization or Third Party, Address, and Phone Number. Additional Third Party Authorization information may be attached separately.

Name of Organization or Third Party

SUNY Maritime College - Licensing Dept.

Organization Point of Contact *(if applicable)*: Charles Smith, Keith Herman

Phone Number: (718) 409 3519

Street Address: 6 Pennyfield Ave

City: Bronx | State: NY | Zip Code: 10465

Signature of Applicant _____ Date (MM/DD/YYYY) _____

c. CONSENT FOR THIRD PARTY TO ACT ON MY BEHALF:

My signature authorizes the following third party **to act on my behalf** in all matters pertaining to the processing of my current application for a medical certificate. This means that the Coast Guard will share my medical information and correspond with the third party, and it means that the third party can request agency action on my behalf, and receive my medical certificate.

I understand that I may revoke this authorization at any time prior to its expiration date by notifying the Coast Guard in writing.

Please provide the Name of the Organization or Third Party, Address, and Phone Number. Additional Third Party Authorization information may be attached separately.

Name of Organization or Third Party

SUNY Maritime College - Licensing Dept.

Organization Point of Contact *(if applicable)*: Charles Smith,k Keith Herman

Phone Number: (718) 409 3519

Street Address: 6 Pennyfield Ave

City: Bronx | State: NY | Zip Code: 10465

Signature of Applicant _____ Date (MM/DD/YYYY) _____