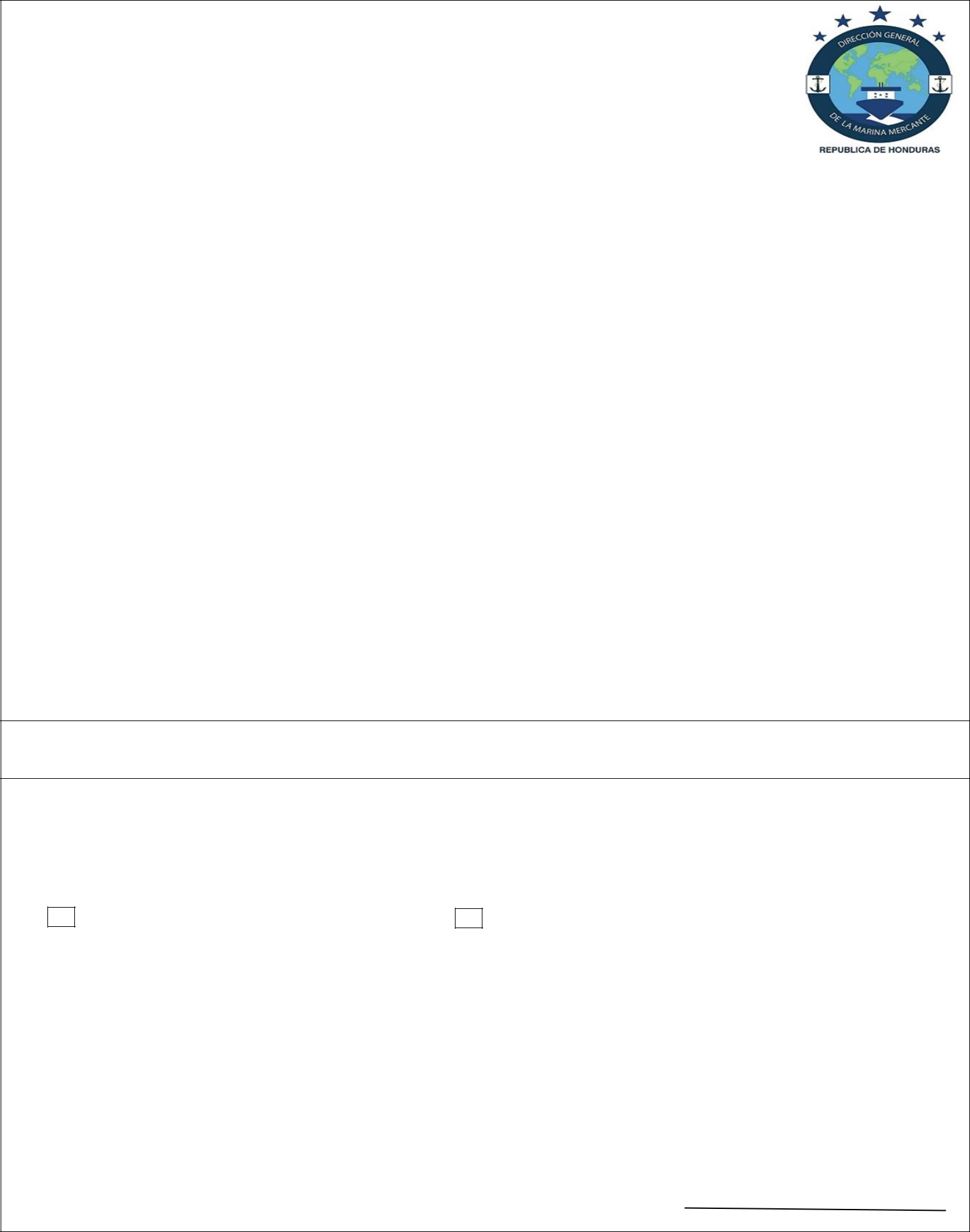
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Acuerdo DGMM N° 016/2012 | | | | |  |  |  |  |  | **CERTIFICADO MEDICO** | | | | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | **PARA EL SERVICIO A BORDO** | | | | | | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  | (MEDICAL CERTIFICATE FOR SHIPS SERVICE) | | | | | | | | |  |  |  |  |  |  |  |
| Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |
| (name) |  |  | Apellido (Surname) | | |  |  |  |  | Nombre (Given Name) | | | | |  |  |  |  |  |  |  |  |  |
| Fecha der Nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexo Masc: | | | | | | | | | | |  |  | Fem: | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| (Date of Birth) | | | | |  |  |  |  | Sex: Masc: | |  |  |  | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | Fem: | | |  |  |  |  |  |  |  |  |  |
| Cargo a Bordo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nacionalidad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |
| (Rank) |  |  |  |  |  |  |  | (Nacionality) | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Domicilio: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |
| (Domicile) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Numero de Cedula o Pasaporte: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |
| (N° ID or Passport) | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | **Visión** | | |  |  |  |  | **Percepción de colores** | | | |  |  |  | **Audición** | | |  |
|  |  |  |  |  |  | **(Vision)** | | |  |  |  |  | **(Color Perception)** | | | |  |  |  | **(Hearing)** | | |  |
|  |  |  |  |  | NO CORREGIDA | | | | CORREGIDAS | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | (NO Correction) | | | | (Corrected) | |  |  | Libro (Book) | | | |  |  | Oído Derecho \_\_\_\_\_\_\_ | | | |  |
|  | OJO DERECHO | | | | 20/ \_\_\_\_\_\_\_\_\_\_ | | | | 20/ \_\_\_\_\_\_\_\_ | |  |  | Linterna (Ligth) | | | |  |  | (Rigth Ear) \_\_\_\_\_\_\_\_\_\_ | | | |  |
|  | (Rigth Eye) | | | | 20/ \_\_\_\_\_\_\_\_\_\_ | | | | 20/ \_\_\_\_\_\_\_\_ | |  | Amarillo \_\_\_\_\_\_ Rojo \_\_\_\_\_ | | | | |  |  |  |  |  |  |  |
|  | OJO IZQUIERDO | | | | 20/ \_\_\_\_\_\_\_\_\_\_ | | | | 20/ \_\_\_\_\_\_\_\_ | |  | (Yellow) \_\_\_\_\_\_ (Red) \_\_\_\_\_ | | | | |  |  | Oído Izquierdo \_\_\_\_\_\_\_ | | | |  |
|  | (Left Eye) | | | | 20/ \_\_\_\_\_\_\_\_\_\_ | | | | 20/ \_\_\_\_\_\_\_\_ | |  | Verde \_\_\_\_\_\_\_\_ Azul \_\_\_\_\_ | | | | |  |  | (Left Ear) \_\_\_\_\_\_\_\_\_\_\_ | | | |  |
|  | Ambos Ojos | | | | 20/ \_\_\_\_\_\_\_\_\_\_ | | | | 20/ \_\_\_\_\_\_\_\_ | |  | (Green) \_\_\_\_\_\_ (Blue) \_\_\_\_\_ | | | | |  |  |  |  |  |  |  |
|  | (Both Eyes) | | | | 20/ \_\_\_\_\_\_\_\_\_\_ | | | | 20/ \_\_\_\_\_\_\_\_ | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  | |  |  |  |  |  |  |
|  |  |  |  |  | Servicio de Cubierta | | | |  | Servicio de Maquina | | | |  | Servicio de Cámara | | |  |  | Otros servicios | | |  |
|  |  |  |  |  |  | (Deck Duty) | | |  | (Engine Duty) | | | |  | (Catering Duty) | | |  |  | (Other Duty) | | |  |
|  | Apto / a | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | (Fit for Duty) | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | No apto / a | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | (Not Fit for Duty) | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Sin restricciones | |  |  |  | Con restricciones | | | Necesita corrección visual | | | | | | si |  |  | no |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | | |  |  |  | | | (Need Visual Corrections) | | | | | | (Yes) |  |  |  |  |  |  |
|  |  | (Without restrictions) | | | |  | (With restrictions) | | | |  |  | (No) | | |  |



Comentarios del historial médico y exploración física (Doctors coments and physical exploration)

La Dirección General de la Marina Mercante de Honduras, **AUTORIZA** a cualquier Medico Certificado, ante el Colegio Médico de Honduras, a extender el Certificado Médico para el Servicio a Bordo. (The General Directorate of The Marchant Marine of Honduras Autorizes: any Certified and registered Medical Doctor, to issued the Medical Certificate for Cervice on Board)

He reconocido y evaluado a la persona arriba citada según las normas nacionales e internacionales. Teniendo en cuenta la declaración personal de la persona reconocida, mi reconocimiento clínico y los resultados de los análisis de laboratorio realizados, DECLARO que la persona reconocida es:

Have I exanimate and evaluated above named person according with National e International norms. Tanking account of study and clinic examine and result of laboratory analysis to make the declaration that the person examined is;

Apto /a para el servicio a bordo

(Fit for Duty on Board)

no apto/a para el servicio a bordo

(Not Fit for Duty on Board)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Lugar donde se realizó el reconocimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |  |
| (Place where examine was carried out) | Nombre de la clínica (Name of Clinic) | | |  |  |
| Ciudad / País \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Fecha del reconocimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |
|  |  |  |  |  |  |
| (City/Country) |  | (Date of Examine) |  |  |  |
| Fecha de expiración del Certificado Médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  |  |
| (Date of Expiration on this Medical Certificate) |  |  |  | Firma y sello del Médico Examinador |  |
| Nombre y número del Médico Examinador: |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | (Signature and seal of Medical Physician) |  |
| (Name and number of Authorized Medical Physican) | |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Por la presente Declaro que me doy por enterado del contenido del reconocimiento Médico realizado: | | | |  |  |
| (I hereby acknowledge the content of the Doctors Recomendation) | | | |  |  |
|  |  | Firma del Reconocido/ Signature of Pacient | | |  |