Maritime Chronic Illness Disclosure Form

Personal Information

Full Name

Date of Birth

Rank/Position

Employee/ID Number

Vessel/Ship Name

Chronic Illness Information

Name of Chronic Illness/Condition

Date Diagnosed

Medications/Treatments

Attending Physician/Specialist

Work Limitations/Restrictions

Additional Information

Describe Symptoms While Onboard

Emergency Procedures/Instructions

Declaration

☐ I confirm the information provided is accurate to the best of my knowledge.

Signature

Date