

30062720



Republic of South Africa

South African Maritime Safety Authority

Seafarer Medical Fitness Certificate

QMS-OP-1003



This certificate is issued under the authority of the SAMSA in accordance with the provisions of Regulation I/9 of the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978, as amended, by the Medical Practitioner approved by SAMSA in accordance with those provisions and the Merchant Shipping (Training, Certification and Safe Manning) Regulations, 2021 (the Regulations)

Surname **MAPSANGATHU** Forename(s) **OSVALDO**
Date of Birth **26 FEBRUARY 1987** Gender Female ☐ Male ☒
Nationality **TIOBANTSI CAN** ID No (SA Citizens)
PP No (non SA Citizens) **A30855791**

Occupation (dept) ☐ Deck ☒ Engine ☐ Catering ☐ Other (specify)

I, the undersigned Medical Practitioner, have evaluated the above-named applicant in accordance with the requirements of Section A-I/9 of the STCW Code and Regulation 88 of the Regulations. On the basis of the applicant's personal declaration, my clinical examination and diagnostic test results recorded on the Medical Examination form, I declare that I have found the applicant to be:

Fit - no limitations or restrictions on fitness ☒
Fit - with limitations as per below ☐
Unfit - details below ☐

The following restrictions or causes applies to the applicant as per above fit - with limitation or unfitness:

Duties

Location/Vessels

Medical

I can confirm the following:

Eyesight

Visual Acuity meets standards Yes ☒ No ☐
Visual Aids required Yes ☐ No ☒
Colour Vision meets standards Yes ☒ No ☐
Date of last colour vision **13 Feb 2024**
Fit for lookout duties (deck) Yes ☒ No ☐

Hearing

Meets hearing standards Yes ☒ No ☐
Unaided hearing satisfactory Yes ☒ No ☐

The applicant is free from any medical condition likely to be aggravated by service at sea, in that it may render them unfit, or endangering the health of others on board. Yes ☒ No ☐

Date of Examination (dd/mm/yyyy) **13 Feb 2024**Date of expiry (dd/mm/yyyy) **12 Feb 2026**

Name of Medical Practitioner

HSPCA Registration number

Signature of Medical Practitioner

**SHIPMED**

PR 0824070
DR N.I PARK-ROSS MBBCH 0764264
DR J.A ADDINGTON MBBCH 0784249
SAMSA/UKOG/DME/NMA/DOH

25 Glenwood Drive, Glenwood
Durban, South Africa, 4001

Tel: +27 31 261 8291 Fax: +27 31 261 4644

I, the applicant, acknowledge that I have been advised of the content of the medical examination form

Signature of Applicant

Version no. - Date	Document	Reference
Ver.1.0 - 10/12/2021	Seafarer Medical Certificate	QMS-OF-1003.6



ShipMed Inc.

7976

Medical Services

Incorporating Shipmed Vaccine Clinic

MEDICAL CERTIFICATION OF FITNESS

Approved by: SOUTH AFRICAN MARITIME SAFETY ASSOCIATION

ILO No: 147, MLC and STCW Manila Amendments and Standards Compliant. MCA APPROVED

Surname: MAPSAMBAWU	Name: OSVALDO MAPSAMBAWU
Address: MOZAMBIQUE, MAPUTO, PARANQUETE	
Postal Code:	
Telephone Number: +258 8784 58348	Nationality: MOZAMBICAN
Passport/ID Number: A308557912	Company/Ship: KETINARE
Job Title:	Sex: MALE



PHOTO

MEDICAL HISTORY. Please tick the appropriate block

Have you suffered from/been diagnosed of:	YES	NO		YES	NO
1 Ear/Nose/throat disease		<input checked="" type="checkbox"/>	20 Stomach pain/Ulcer		<input checked="" type="checkbox"/>
2 Asthma		<input checked="" type="checkbox"/>	21 Other Abdominal/Bowel trouble		<input checked="" type="checkbox"/>
3 Tuberculosis/Chronic cough		<input checked="" type="checkbox"/>	22 Prostate disorder		<input checked="" type="checkbox"/>
4 Other Lung disease		<input checked="" type="checkbox"/>	23 Kidney/Bladder/other Urological problem	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5 High Blood pressure		<input checked="" type="checkbox"/>	24 Hepatitis/Liver Disease		<input checked="" type="checkbox"/>
6 Heart trouble		<input checked="" type="checkbox"/>	25 Sexually transmitted disease		<input checked="" type="checkbox"/>
7 Varicose veins/Haemorrhoids		<input checked="" type="checkbox"/>	26 Genetic or Familial disorders		<input checked="" type="checkbox"/>
8 Rheumatic fever		<input checked="" type="checkbox"/>	27 Malaria (if yes, date of last attack)		<input checked="" type="checkbox"/>
9 Diabetes Mellitus		<input checked="" type="checkbox"/>	28 Operations/Hospitalisation	<input checked="" type="checkbox"/>	
10 Thyroid disorder		<input checked="" type="checkbox"/>	29 Tropical diseases		<input checked="" type="checkbox"/>
11 Other Endocrine disorders		<input checked="" type="checkbox"/>	30 Fainting spells, fits or seizures		<input checked="" type="checkbox"/>
12 Cancer/Tumor/Abnormal blood disorders		<input checked="" type="checkbox"/>	31 Frequent headaches		<input checked="" type="checkbox"/>
13 Mental/Psychiatric disorders		<input checked="" type="checkbox"/>	32 Dizziness		<input checked="" type="checkbox"/>
14 Head or neck injury		<input checked="" type="checkbox"/>	33 Allergies/Hayfever		<input checked="" type="checkbox"/>
15 Back/Bone disease/Injury		<input checked="" type="checkbox"/>	34 Any intake of medication		<input checked="" type="checkbox"/>
16 Rheumatism/Arthritis/Joint Injury		<input checked="" type="checkbox"/>	35 Drug usage/Failed drug test/Excessive drinking		<input checked="" type="checkbox"/>
17 Hernia		<input checked="" type="checkbox"/>	36 Serious Illness or injury		<input checked="" type="checkbox"/>
18 Typhoid or Paratyphoid fever		<input checked="" type="checkbox"/>	37 Under a Doctor's care		<input checked="" type="checkbox"/>
19 Trachoma or other eye trouble		<input checked="" type="checkbox"/>	38 Signed off/Declared unfit on medical grounds		<input checked="" type="checkbox"/>

Comments (To be completed by the examining Physician)

36g. 5th
28. Widespread signs of

I am able to read, write and speak English, and I fully understand the above questions. I affirm that the above answers are true and correct to the best of my knowledge and belief. I understand that falsification is grounds for termination without benefits. I authorise release of any medical information concerning my past, present or future medical condition, by any practitioner or hospital, to my company or their representatives. As per ILO No 147, MLC and STCW MANILA Amendments requirements.


SIGNATURE OF APPLICANT

13 FEB 2024
DATE OF EXAMINATION

ShipMed Inc.

Medical Services
Incorporating Shipmed Vaccine Clinic

PHYSICAL EXAMINATION

HT: 171 CM	WT: 69.45 KG	BMI: <u>23.7</u> /min	BP: 128/78	PULSE: 70	RESP: 16 /min	TEMP: 36°C
AUDIOLOGICAL	250	500	1000	2000	3000	4000
LEFT EAR						
RIGHT EAR						
VISUAL	Distance vision		Visual Fields	Night Vision	ISCHARA Colour Vision	
	Uncorrected	Corrected			Adequate	
LEFT EYE	6/6				Defective: [G [] R [] Y [] B []	
RIGHT EYE	6/6					
TEST	Normal/Yes	Abnormal/No	Results/Comments			
Examination performed by AME						
Orbit/Adnexae						
Ophthalmic Examination						
Pupils (reaction/size)						
Eye movements						
Corrective Lenses used						
TEST	NML	ABN				
1 Head			11 Psychiatric behaviour			
2 Ears Nose and Throat			12 Extremities			
3 Neck and Thyroid			13 Reflexes			
4 Dental Examination			14 Skin			
5 Neurological Examination			15 Hernial orifices			
6 Lymphatic System			16 Rectal examination (>40yrs)			
7 Heart and Cardiovascular Exam			17 Back			
8 Lungs/Chest/Axilla			18 Venous/Vascular system			
9 Abdomen			19 Deformities/Limitations of			
10 Genito-urinary (Pelvic if required)			20 Hands and feet			
			21 Scars/Skin lesions			
COMMENTS BY EXAMINING PHYSICIAN:						

SPECIAL EXAMINATIONS AND LABORATORY REPORT

A CHEST X-RAY: [] PA [] LORDOTIC [] NORMAL [] ABNORMAL	H HEPATITIS B SURFACE ANTIGEN TEST (HBSag): [] REACTIVE [] NOT REQ'D [] NON REACTIVE
B LUNG FUNCTION: [] NORMAL [] ABNORMAL [] NOT REQ'D	I AIDS CLEARANCE TEST: [] REACTIVE [] NON REACTIVE
C ECG REPORT: [] NORMAL [] SIGNIFICANT FINDINGS _____ / _____	J PREGNANCY TEST/LAST MENSTRUATION PERIOD: [] POSITIVE [] NOT REQ'D [] NEGATIVE
D BLOOD SUGAR: <u>5.9</u> mmol/L	K 7 PANEL DRUG TEST: [] NORMAL [] ABNORMAL
E FULL BLOOD COUNT: _____ hgb _____ ESR [] NORMAL [] ABNORMAL	L URINALYSIS: [] NORMAL [] ABNORMAL No dep
F SEROLOGICAL TEST (VDRL/RPR): [] REACTIVE [] NOT REQ'D [] NON REACTIVE	APPEARANCE: <u>Amber</u> Ph: <u>6.5</u> PROTEIN: <u>Neg</u> SUGAR: <u>Neg</u> BLOOD: <u>Neg</u>
G HEPATITIS A ANTIBODY TEST (IgM): M [] REACTIVE [] NOT REQ'D [] NON REACTIVE	OTHERS: _____

COMMENTS BY EXAMINING PHYSICIAN:

I FIND THIS APPLICANT FIT FOR THE POSITION APPOINTED: [] YES [] NO

CERTIFICATE VALID FROM: 13 FEB 2024 UNTIL: 12 / 02 / 2026

CERTIFICATE ISSUED:

[] YES [] NO

LIMITATIONS: _____

SHIPMED

PR 0824070

DR N.I PARK-ROSS MBBCH 0764264

DR J.A ADDINGTON MBBCH 0784249

SAMSA/UKOG/DME/NMA/DOH

25 Glenwood Drive, Glenwood

CONFIDENTIAL

Employee Name & Surname	<u>OSWALDO TAPSAKARU</u>
Identification Number	<u>AB0855791</u>
Date of Birth	<u>26 FEBRUARY 1987</u>
Date of Test	<u>13 FEBRUARY 2024</u>

In accordance with the regulations, as set in the ILO/IMO guidelines and those of the authorising authority, a urine sample will be analysed for the below substances using rapid reagent strips or via urine microscopy. The procedure follows the chain of custody as outlined in ShipMed's ISO 9001 Policy.

	Positive	Negative	Notes
Blood		✓	
Glucose		✓	
Protein		✓	
Leukocytes		✓	
Nitrates		✓	
Bilirubin		✓	
Urobilinogen		✓	
Ketones		✓	


Pregnancy test, if required

Pregnancy	<u>N/A</u>
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SG 1.005
 pH 6.5
 Temp 35 °C



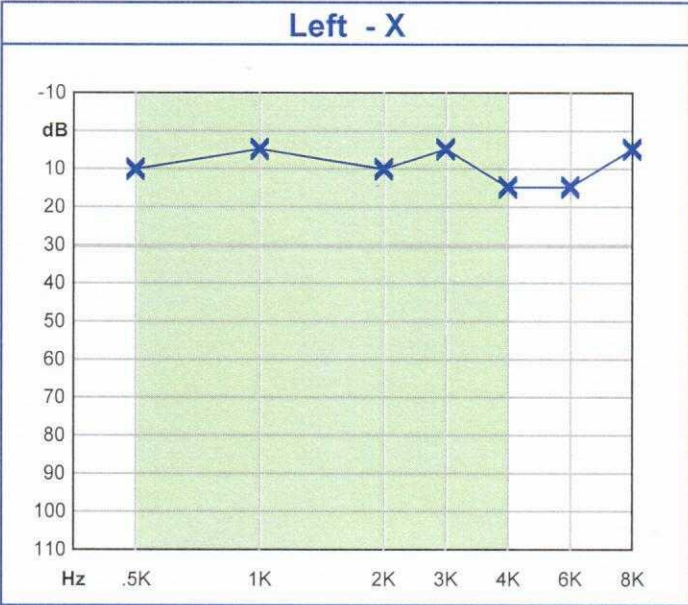

 Patient Signature


 Staff Signature



Patient Number:	AB0855791	Company:	SAMSA
Patient Name:	MAPSANGANHE, OSVALDO HENRIQUE	Department:	DECK
ID No.:	AB0855791	Position:	2ND DECK OFFICER
Date of Birth:	26 Feb 1987	Environment:	Other (No Hazard)
Gender:	Male		


Test Date:	13 Feb 2024 14:39:38	Reference:	-	Operator:	clinic
Baseline Type:	-	Otoscopic:	N/A		
PLH (Shift):	1.10 (1.1)	PLH Contributions:	.5K= 0.20, 1K= 0.50, 2K= 0.30, 3K= 0.10, 4K= 0.00		
ST; L / R (Shift):	10.00 / 8.33 (10.0 / 8.3)				
Audiometer:	Tremetrics RA300	Last Calibration:	2024-02-12	Next Calibration:	2025-02-12
Serial No.:	082736	Calibrated By:	Musa Nzama		




Identifier	Test Date	Otos.	Test Type	Baseline Type	Left - X								Right - O							
					.5K	1K	2K	3K	4K	6K	8K	.5K	1K	2K	3K	4K	6K	8K		
Blue	13 Feb 2024 14:39:	-	O A Screening		10	5	10	5	15	15	5	5	10	10	5	10	0	5		

Identifier	Test Date	Age	PLH Shift					ST (L)	ST Shift (Left)				ST (R)	ST Shift (Right)				ABHL
			PLH	Prev.	Clinic	R-171			Prev.	Clinic	OHSA	R-839		Prev.	Clinic	OHSA	R-839	
Blue	13 Feb 2024 14:39:	36	1.1	-	-	1.1	10.0	-	-	-	10.0	8.3	-	-	-	8.3	7.5	




 MAPSANGANHE, OSVALDO HENRIQUE

13/02/2024
 Date:


 Shipmed
 clinic

13/02/2024
 Date:

Passaporte
Passport

República de Moçambique / Republic of Mozambique

Tipo/Type PN Código do País/Country code MOZ
Passaporte Nº/Passport Nº AB0855791

Apelido/Surname
MAPSANGANHE

Nome/Given name(s)
OSVALDO HENRIQUE FRANCISCO

Nacionalidade/Nationality
MOÇAMBICANA

Data de Nascimento/Date of birth
26/02/1987

Sexo/Sex M Local de Nascimento/Place of birth
MAPUTO

Data de Emissão/Date of issue
30/09/2020

Válido até/Date of expiry
29/09/2025

Nº BI/ID Nº
110100553164M


Autoridade Emissora/Issuing authority
SERVIÇO NACIONAL DE MIGRAÇÃO

Assinatura do Titular/Signature of holder

Osvaldo Henrique Francisco

PNMOZMAPSANGANHE<<OSVALDO<HENRIQUE<FRANCISCO
AB08557916MOZ8702263M2509297110100553164M<38



	PERSONAL DATA AND MEDICAL MANAGEMENT CONSENT FORM	Revision no	0
		Date	13/12/2022
		Document no	8.1_CON03

INFORMED CONSENT
 PROVIDED BY PATIENT /PARENT /GUARDIAN
 ("the data subject" and also "the signatory")
 IN TERMS OF **THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013 (POPIA)**
 FOR PERSONAL INFORMATION TO BE COLLECTED AND PROCESSED BY

SHIPMED INCORPORATED

("the responsible party", "practice", "health care provider" and also "the company")

A. CONSENT FOR THE PROCESSING AND USE OF PERSONAL INFORMATION

I understand and agree that:

SHIPMED is a medical practice providing medical services to its patients and as part of its business functions and responsibilities the practice collects and processes Personal Information and is required in some circumstances to supply third parties the collected information.

The practice collects, stores, uses, handles, processes, transfers, retains, archives, and otherwise manages Personal Information.

In order to discharge this duty, the Responsible Party requires my express and informed permission to collect and to process my Personal Information or that of my minor dependent/s and adult dependents who are unable to provide their own consent.

Medical information includes: (i) my entire medical record and medical history, prescription history, and other health information (ii) confidential information related to Human Immunodeficiency Virus (HIV) or Aids, other communicable diseases, and mental illness (including psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law.

Purpose. I consent to the practice sharing my Personal Information with 3rd party healthcare providers, medical schemes, administrators, service providers and any contracted third parties necessary for the provision of any service to me. I further agree that Personal Information provided to the practice will be used:

- to give effect to my contractual relationship with the practice and to conduct its operations for the provision of medical related services to me and/or my dependents and for any referrals to other specialists and service providers.
- to provide a report to the practice's indemnity or insurance providers and/or employer and the recipient will be notified of the need to protect the confidentiality of the personal information.
- to comply with obligations required by any legislation affecting this practice.
- to protect the legitimate interests of the practice, myself and or any third parties.
- to store my personal health information in a secure manner in any format.
- to furnish my medical scheme for services provided to me or my dependents.
- for medical research purposes.
- to access mine or my dependents medical scheme benefits.
- to provide or authorise emergency medical services to me or my dependents.
- in terms of the statutory and ethical limits.
- to transfer to specialists who will access, view, and store my personal health information. The practice cannot guarantee the security or integrity of any information that I transmit to the specialist practice online or otherwise, and I agree and understand that I do this at my own risk.
- in connection with legal proceedings including debt collection;

I understand and agree that if the practice does not have my or my dependents consent, the practice will not be able to commence treatment and cannot share my Personal Information with any specialists/sub-contractors/other providers to optimise my healthcare treatment. I understand that I can withhold consent to the practice collecting and processing my Personal Information.


I agree that in the event that I withhold my consent the practice will not be able to provide any medical or related services to me and I accept that I will be liable for any costs expended by the practice up to the point where I withheld my consent and agree that I will not be granted any medical reports or similar for such payments.

Storage of personal information. My Personal Information will be stored electronically or in hard copy in a safe and secure environment. Hard copies of Personal Information will be stored and retained safely under lock and key. After I am no longer an active patient, my Personal Information will be retained for as long as law or practice's indemnity/insurance providers require it. The practice will not retain Personal Information for longer than is necessary and for the required purpose. The exceptions to the above principle specifically provided in POPIA are where –

- the retention of the record is required or authorised by law;
- the practice reasonably requires the record for lawful purposes related to its functions or activities;
- the retention of the record is required in terms of an agreement between the practice and myself, or
- the record is retained for historical purposes, with the practice having established appropriate safeguards against the record being used for any other purpose.

When the Personal Information is no longer required by process or legation, it shall be destroyed or deleted in a manner that prevents their reconstruction in an intelligible form.

Intended recipients. I agree the intended recipients of my Personal Health Information are me, healthcare providers (including the staff of ShipMed), specialists, pathologists, my employer, or their appointed agent (including practice staff or their practice staff),

	PERSONAL DATA AND MEDICAL MANAGEMENT CONSENT FORM	Revision no	0
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		Document no	8.1_CON03

medical schemes/administrators, facilities, researchers, emergency medical service providers. Such disclosure shall always be made between the practice and recipient to comply with strict confidentiality and security conditions as contained in POPI Act.

Transfer outside South Africa I agree to the practice transferring any Personal Information outside of the borders of South Africa to its indemnity providers that has in place similar privacy laws to POPIA, or the recipient is bound contractually to no lesser terms of POPIA.

I understand that I have the right to have my Personal Information processed in accordance with the eight conditions of lawful processing of Personal Information as set out in POPIA. The eight conditions being; Accountability, Processing Limitation, Purpose Specific, Further Processing Limitation, Information Quality, Openness, Security Safeguards, and Data Subject Participation.

The Practice Information Officer can be contacted via the email address: consent@shipmed.co.za

I consent to ShipMed attending to medical testing and to the taking of specimens (such as, but not limited to, blood, urine, breath, and stool) for the purpose of my assessment.

I acknowledge and agree that the Health Check I am about to undergo will provide information to evaluate my state of Health. This health check will be conducted by employees of ShipMed.

I hereby agree that this is a medical screening assessment for consideration by my prospective employer for job assignment purpose only. Whilst medical conditions need to be addressed, any treatment or discussions related to the management of them will need to be consulted in a separate appointment with my treating physician.

I further understand that I have a right to receive my personal information and consent to such information being relayed to me by email, fax, WhatsApp, or any further electronic communication.

I agree that a copy, including photostat, electronic, or fax copy of this signed form shall be considered as effective and valid as the original and specially authorize its use as such.

I will not hold the practice responsible for any loss (whether direct or indirect) that may arise from the use of my Personal Information.

I may not hold the practice responsible for any loss that may result from the incorrect use or disclosure of the information by any healthcare provider to whom the practice has provided the Personal Information.

I agree to give permission to the practice to give my medical scheme, administrator, employer or my employers agent details of my diagnosis and clinical information required.

I agree that I had an opportunity to read the terms and conditions (or they have been read to me), and I fully understand the consequences of these terms and conditions. I had sufficient opportunity to ask questions about this consent form and questions, answered to my satisfaction by the practice.

My consent is provided of my own free will without any undue influence from any person whatsoever.

I confirm that I have permission of my dependant(s) to give their consent. Where such consent has been provided, I indemnify the practice against this.

This signed form is valid until revocation signed by me is received by ShipMed. I acknowledge that if I sign this form, I will have the right to revoke it at any time. To revoke this consent and/or authorization, I must do so in writing to ShipMed INC.


By signing this consent form, I confirm that I have read and fully understood the above terms and conditions. I also declare that statements made on this form are accurate and all known medical history has been stated. I acknowledge that ShipMed Inc, will rely upon the accuracy and completeness of all statements made by me.

Full name OSVALDO MARSANGATHE

Date 13 FEBRUARY 2024

Cell number +258 87 84 58 348

E-mail address OSVALDOMARSANGATHE@YAHOO.COM

Sign 
Patient/Parent/Guardian