DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

OMB No. 1625-0040
Exp. Date: 09/30/2028

APPLICATION FOR MEDICAL CERTIFICATE, SHORT FORM

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

Who must submit this form?

1. Mariners applying for, or holding a Merchant Mariner Credential (MMC) with only an entry-level national endorsement or a staff officer national endorsement **who want to serve as Food Handler** may use this form. (Please include the instruction page in addition to sections I, II, V and VI of this form.)
2. Mariners applying for or holding an MMC with only an entry-level endorsement or a staff officer endorsement who require a medical certificate that complies with the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (**STCW**) or, Maritime Labour Convention (**MLC**) requirements and **will not stand navigational or engineering watches** may apply using this form. No lookout duties will be authorized.
3. All other applicants for a Medical Certificate must use the Application for Medical Certificate, Form CG-719K.

Who may conduct this exam?

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.

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

- **Legal Name** - Enter complete legal name.
- **Reference Number** - If you have been credentialed by the Coast Guard in the past, enter your reference number.
- **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.
- **Sex** - Select your sex.
- **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** *(optional)* - If provided, **t**he 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)*.

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: Physical Information - To be completed by the Medical Practitioner

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

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

Applicants must provide a demonstration of physical ability as described in the table and instructions in this section. The **Medical Practitioner** should initial and date at the bottom of each page of the application, where indicated**.**

Section V: 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 (TWIC).

b. **Certification Recommendation** - The **Medical Practitioner** should provide their recommendation and overall opinion of the mariner's fitness.

c. Assessment - For STCW/MLC compliant medical certificate.

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

e. **Medical Practitioner** (Attestation and Information) - The **Medical Practitioner** must sign and date the attestation where indicated.

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

Applicant certifies that the information provided is true and correct.

Section VII: 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. 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)* _____

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APPLICATION FOR MEDICAL CERTIFICATE, SHORT FORM

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)* | Sex ☐ 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 ☐

City | State | Zip Code | Other ☐

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

Section III: Physical Information - To be completed by the Medical Practitioner

Height *(Inches Only)* | Weight *(lbs)*

Distinguishing Marks*:* ***(Please Print)***

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

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

Section IV: 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	Distinguish an object or shape at a certain distance
React to audible alarms and instructions, emergency response procedures	React to audible alarms and instructions, emergency response procedures	React to audible alarms and instructions, emergency response procedures
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

Title 46 of the Code of Federal Regulations (CFR) requires that ratings, including entry level, and food handler serving on vessels to which STCW applies must provide a demonstration of physical ability. The table above lists activities that the applicant must be physically able to perform: For a vessel to be operated safely, it is essential that the crewmembers be physically fit and free of debilitating illness and injury. The seafaring life is arduous, often hazardous and the availability of medical assistance or treatment is generally minimal. As the international trend toward smaller crews continues, the ability of each crewmember to perform his or her routine duties and respond to emergencies becomes even more critical. All mariners should be capable of living and working in cramped spaces, frequently in adverse weather causing violent evolutions such as firefighting or launching lifeboats or life rafts. Members of the deck and engine department must be capable of physical labor, climbing, and handling moderate weights (from 30-60 pounds). Refer to the Merchant Mariner Medical Manual, which can be found at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF , for further guidance or call the NMC at 1-888-IASKNMC (1-888-427-5662).

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 V: 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: (for STCW/MLC compliant medical certificate) To the best of my knowledge, mariner 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 Evaluation

d. Discussion: Please discuss any concerns. Please print or type.

e. Medical Practitioner:

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.

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 VI: 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 Notice that accompanies this form.

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

PRIVACY ACT STATEMENT

Pursuant to 5 U.S.C. §552a(e)(3), this Privacy Act Statement serves to inform you of why DHS is requesting the information on this form.
AUTHORITY: 14 U.S.C. § 505; 46 U.S.C. §§ 2103, 7101, 7302, 7502; 46 C.F.R. 10.301
PURPOSE: To determine whether an applicant meets the regulatory standards for issuance of a U.S. Merchant Mariner Credential (MMC). The U.S. Coast Guard (USCG) 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 USCG 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 USCG uses the information to maintain and update records of merchant mariner document transactions. This information will not be shared outside of DHS except in accordance with the provisions of DHS/USCG-030, Merchant Seamen's Records, 74 Federal Register 30308 (June 25, 2009); and DHS/USCG/PIA-015, Merchant Mariner Licensing and Documentation System.
CONSEQUENCES OF FAILURE TO PROVIDE INFORMATION: 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 10 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.

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

Section VII: *(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 4 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:

- u 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.
- u Upon request, I may see or copy the information described in this release.
- u 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

Organization Point of Contact *(if applicable)* | Phone Number

Street Address

City | State | Zip Code

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.

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

Organization Point of Contact *(if applicable)* | Phone Number

Street Address

City | State | Zip Code

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