

APPLICATION FOR MEDICAL CERTIFICATE

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.

----- 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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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.
- **Sex** - Enter 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 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 Merchant Mariner Medical Manual which can be found at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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. 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*) _____

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

OMB No. 1625-0040
Exp. Date: 02/21/2028

APPLICATION FOR MEDICAL CERTIFICATE

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mariner Reference Number or Social Security Number	Sex:	Date of Birth (MM/DD/YYYY)	
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	

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

Home Address (PO Box NOT acceptable) <input type="checkbox"/>	Primary Phone Number <input type="checkbox"/>
Street Address <input type="text"/>	<input type="text"/>
City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>	Alternate Phone Number <input type="checkbox"/>
<input type="text"/>	<input type="text"/>
Delivery/Mailing Address, if different (PO Box acceptable) <input type="checkbox"/>	E-mail Address <input type="checkbox"/>
Street Address <input type="text"/>	<input type="text"/>
City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>	Other <input type="checkbox"/>
<input type="text"/>	<input type="text"/>

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

- 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.
- 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.
- 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:
 - 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.
 - 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.
 - 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 Merchant Mariner Medical Manual, located at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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

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Condition Treatment

Status Limitations

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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

- 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**
- 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

- Medical Practitioner must verify applicants medications and information listed in the table below.
- 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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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	<input type="checkbox"/>	<input type="checkbox"/>	7. Upper/Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	13. Skin	<input type="checkbox"/>	<input type="checkbox"/>
2. Eyes/Pupils/EOM	<input type="checkbox"/>	<input type="checkbox"/>	8. Spine/Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	14. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
3. Mouth and Throat	<input type="checkbox"/>	<input type="checkbox"/>	9. Vascular System	<input type="checkbox"/>	<input type="checkbox"/>	15. Mental Status	<input type="checkbox"/>	<input type="checkbox"/>
4. Ears/Drums	<input type="checkbox"/>	<input type="checkbox"/>	10. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>		No	Yes
5. Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>	11. General/Systemic	<input type="checkbox"/>	<input type="checkbox"/>	16. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart	<input type="checkbox"/>	<input type="checkbox"/>	12. Extremities/Digit	<input type="checkbox"/>	<input type="checkbox"/>			

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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF.

a. Visual Acuity

Distance Vision, Uncorrected: If correction required, Distance Vision Correctable To:

Right: 20/

Right: 20/

Left: 20/

Left: 20/

Field of Vision

Normal (the applicant's horizontal field of vision is greater than or equal to 100 degrees).

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)

Ishihara pseudoisochromatic plates test, 14 plate (5 or less errors)

AOC-HRR (2nd Edition) - (No errors in test plates 7-11)

Ishihara pseudoisochromatic plates test, 24 plate (6 or less errors)

HRR PIP (4th Edition) - (No errors in test plates 5-10)

Ishihara pseudoisochromatic plates test, 38 plate (8 or less errors)

Richmond (2nd and 4th Edition) - (6 or fewer errors)

Farnsworth Lantern (colored lights) Test per instruction booklet

Titmus Vision Tester/OPTEC 2000 - (No errors on 6 plates)

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

OPTEC 900 (colored lights) Test per instruction booklet

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 > 30 dB in the better ear should have functional speech discrimination testing performed at 65dB.

(c) 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. Report any additional information or comments in Section IX.

Audiometer Threshold Value

	500Hz	1,000Hz	2,000Hz	3,000Hz	Average
Right Ear (Unaided)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Left Ear (Unaided)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Right Ear (Aided)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Left Ear (Aided)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:** _____

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 (<i>equilibrium</i>)	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 (<i>lowering height by bending knees</i>); kneel (<i>placing knees on ground</i>); stoop (<i>lowering height by bending at the waist</i>); use hand tools such as span-ners, 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 (<i>ability to move body using hands and knees</i>); feel (<i>ability to handle or touch to examine or determine differences in texture and temperature</i>)	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 uncharged 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 Merchant Mariner Medical Manual which can be found at https://media.defense.gov/2019/Sep/11/2002181050/1-1/0/CIM_16721_48.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.

We can only accept applications completed by MD, DO, PA or NP.

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)

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.

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

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.

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)

APPLICATION FOR MERCHANT MARINER CREDENTIAL (FORM CG-719B)

----- Instructions -----

Who must submit this form?

1. Applicants seeking a Merchant Mariner Credential (MMC), whether original, renewal, duplicate, raise of grade, or a new endorsement on a previously issued MMC and applicants requesting a Medical Certificate.
2. Application Assistance: Please call the National Maritime Center (NMC) at 1-888-IASKNMC (1-888-427-5662), or visit their website for more information. www.uscg.mil/nmc.

Section I: Applicant Information

- I.1 **Legal Name** - Enter complete legal name. Include any aliases you have used and your maiden or prior name(s).
- I.2a **Social Security Number** - If you are applying for an original credential, enter your SSN.
- I.2b **Reference Number** - If you have been credentialed by the Coast Guard in the past, enter your reference number.
- I.2c **Alien Registration Number** - If you are a legal alien, also enter your alien registration number (ARN).
- I.3 **Date of Birth** - If the applicant is under 18 years of age, a notarized statement from legal guardian is required. Attach a notarized statement, signed by a parent or legal guardian, authorizing the Coast Guard to issue a credential.
- I.4 **Citizen** - If not a U.S. citizen, please indicate country of nationality.
- I.5a-c **Place of Birth** - City, State, Country. If born outside the United States, leave State blank.

Section I: Applicant Address and Contact Information (If NMC is unable to contact you, it could cause delays in processing your application.)

- I.6a **Home Address** - Principle place of residence. **PO Box is NOT acceptable.**
- I.6b **Delivery/Mailing Address** - The address to which you want all correspondence and issued credentials sent. If blank, correspondence and credentials will be sent to the Home Address.
- I.6c **Primary Phone Number** - Provide a primary phone number.
- I.6d **Alternate Phone Number** - Provide an alternate phone number if available.
- I.6e **E-mail Address** - The NMC may attempt to contact you via e-mail. If an e-mail address is provided, you will receive automated e-mail updates regarding the status of your application.
- I.6f **Other** - Please provide additional means of communicating with you (*satellite phone, work phone, etc.*) if available.

Section I (continued): Next of Kin/Emergency Contact: (Check the box for preferred contact method)

- I.7a **Next of Kin/Emergency Contact** - Name & Mailing Address, City, State, Zip Code.
- I.7b **Relationship** - Provide relationship status to next of kin listed on application. (*i.e. Mother, Father, Spouse*)
- I.7c **Primary Phone Number** - Phone number to contact the person listed in the event of an emergency.
- I.7d **Alternate Phone Number** - Provide a cellular phone number, if available.
- I.7e **E-mail Address** - Provide an e-mail address for Next of Kin listed.

Section II: Requested Merchant Mariner Credential (MMC) and endorsements (Including Certificate of Registry)

General Application Requirements:

An applicant must establish that he or she satisfies all the requirements for the MMC and endorsement(s) sought before the MMC is issued. The Coast Guard may refuse to process an incomplete MMC application.

- A quick reference table for the requirements of an MMC and any endorsement is available online at: [46 CFR 10.239](http://46CFR10.239)
- More information is available on the National Maritime Center (NMC) website: www.uscg.mil/nmc

MMC and Endorsement Application Descriptions:

All Mariners will receive a single Merchant Mariner Credential. Describe all desired capacities and limitations both national and STCW including tonnage, waters, propulsion mode, horsepower, ratings (*Ordinary Seaman, Able Seaman, QMED-Oiler, etc.*), purser, doctor, radio operator, continuity, etc.

1. **Original MMC** - An applicant must apply for an original MMC if they have never held any Coast Guard issued credential or if the first credential issued to applicant after their previous credential was revoked pursuant to 46 CFR Part 10. Complete the application and ensure all mandatory documents are contained with application.
2. **Renewal MMC** - A credential may be renewed at any time during its validity and for one year after expiration; you must be qualified to renew all Domestic/STCW Officer and Rating endorsements to receive an MMC with a new five year expiration date. An MMC renewal-only transaction will automatically be issued with a date that coincides with the expiration date of your previous credential or a date that is 8-months from the time the Coast Guard accepted your application, whichever is sooner. Page 3, Section II of this form provides you the opportunity to decline this post-dating feature and your MMC will be valid immediately.

3. **Duplicate MMC** - In the event of a lost credential, a statement describing the circumstances of the loss must be submitted with the application. The duplicate will have the same authority, wording and expiration date as the lost credential. If a person loses a credential by shipwreck or other casualty that causes damage to a ship, a duplicate will be issued free of charge as per 46 CFR 10.229. If a person loses a credential by other means and applies for a duplicate, the appropriate fee set out in 46 CFR 10.219 must be paid. No application from an alien for a duplicate credential will be accepted unless the alien complies with the requirements of 46 CFR 10.229.
4. **MMC Endorsement(s)** - This is a statement on a mariner's MMC that indicates that he or she is qualified to serve in that capacity. All endorsements including National officer and National rating endorsements as well as all STCW endorsements (International) are listed in [46 CFR 10.109](#).
NOTE: Requests for an endorsement(s) will not change the expiration date of a mariner's MMC unless the applicant also requests a renewal MMC and meets the renewal requirements of all endorsements on the MMC in accordance with 46 CFR 10.227.
 - (a) **Raise of Grade (ROG) Endorsement** - The requirements for a ROG are found in 46 CFR 10.231. This is an increase in the level of authority and responsibility associated with an existing officer or rating endorsement.
 - (b) **Increase in Scope** - The requirements for an Increase in Scope are found in 46 CFR 10.223. This is a modification or a removal of limitations or scope to existing MMC endorsement(s).
5. **Document of Continuity** - This is a record of qualifications previously held and does not authorize the holder to sail in any capacity listed thereon. Documents of continuity do not expire, do not require medical or security evaluations, and do not require fees. STCW endorsements may not be placed in continuity. No credential expired beyond the 12-month administrative grace period described in 46 CFR 10.227(h) can be converted into a Document of Continuity.
6. **Entry Level Ratings** - There are no professional requirements needed when applying for entry level credential. Ratings may include Ordinary Seaman, Wiper, and/or Stewards Department / Stewards Department (*Food Handler - F.H.*). Per 46 CFR Part 10, applicants requesting Stewards Department (F.H.) will be required to submit a statement from a physician attesting that the applicant is free from communicable disease.

Section III: Safety and Suitability

III. 1 Transportation Worker Identification Credential (TWIC):

- A TWIC is required for applicants who need access to secure areas designated in a vessel's security plan and a facility's security plan by the Maritime Transportation Security Act.
- Unless specifically exempted, the Coast Guard must have evidence that you hold a valid TWIC or, for original applicants, that you have applied for a TWIC and are awaiting the results.

III. 2a-f Criminal Record Review (Convictions and Drug Use):

In accordance with 46 CFR 10.211, the Coast Guard may review the criminal record of an applicant to determine meet safety and suitability of all applicants before any MMC and any endorsement is issued. At the time of application you must provide a written disclosure of all prior convictions NOT previously disclosed.

- **Original Applicants are required to list ALL convictions.**
- **Written Disclosures** - Applicants may use the optional form (CG-719C) to provide written disclosure of all convictions.
- **Conviction means** that the applicant for a merchant mariner credential has been found guilty, by judgment or plea by a court of record of the United States, the District of Columbia, any State, territory, or possession of the United States, a foreign country, or a military court, of a criminal felony or misdemeanor or of an offense described in section 205 of the National Driver Register Act of 1982, as amended (49 U.S.C. 30304). If an applicant pleads guilty or no contest, is granted deferred adjudication, or is required by the court to attend classes, make contributions of time or money, receive treatment, submit to any manner of probation or supervision, or forgo appeal of a trial court's conviction, then the Coast Guard will consider the applicant to have received a conviction. A later expungement of the conviction will not negate a conviction unless the Coast Guard is satisfied that the expungement is based upon a showing that the court's earlier conviction was in error.

III.3 National Driver Registry (NDR):

- No MMC will be issued as an original or reissued with a new expiration date, and no new officer endorsement will be issued if the applicant fails the criminal record review in accordance with 46 CFR 10.213.

Section IV: Applicant Consent and Certification

- IV.1 **Mariner Outreach System:** This is an optional program used by the Maritime Administration in the event of a national emergency. Applicant will need to select whether Yes, they would like to participate, or No, they do not wish to participate in the Mariner Outreach System, by selecting either of the check boxes.
- IV.2 **Continuity:** Credentials issued for continuity purposes are not valid for use.
- IV.3 **Consent:** Applicants under the age of 18 must attach a notarized statement of parental/guardian consent.
- IV.4 **Certification:** Applicant certifies that the information provided is true and correct. Every person who applies for an original MMC must first take an oath. The applicant must sign and date the application stating they have taken the oath. Failure to sign will result in the application being returned. Per 46 CFR 10.225(c), an oath may be administered by any Coast Guard designated individual or any person legally permitted to administer oaths in the jurisdiction where the person taking the oath resides.
- IV.5 **Signature and Date:** Failure to sign and date the application will result in the application being returned.
- IV.6 **Third Party Authorization (optional):** If you want the NMC to be able to discuss, release, or receive information/documents regarding your credential 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 Releases, attach additional pages as needed. A sample may be found on the NMC website: <http://www.uscg.mil/nmc/>.

APPLICATION FOR MERCHANT MARINER CREDENTIAL (FORM CG-719B)

Section I: Applicant Information

1. Legal Name: Last First Name Middle Name Suffix (*Jr., Sr., III*) Alias(es) or Maiden Name(s) if applicable

2a. SSN (*for Original only*) 2b. Reference Number (*if applicable*) 2c. Alien Registration Number (*ARN*) (*if applicable*) 3. Date of Birth (MM/DD/YYYY)

4. Citizenship 5a. Place of Birth (*City*) 5b. State 5c. Country 5d. Color of Eyes 5e. Color of Hair

Applicant Address and Contact Information (*Please indicate best method(s) of contact by checking the appropriate box(es).*)

6a. Home Address (*PO Box NOT acceptable*)
 Street Address 6c. Primary Phone Number

City State Zip Code 6d. E-mail Address

6b. Delivery/Mailing Address, if different (*PO Box acceptable*)
 Street Address 6e. Alternate Phone Number

City State Zip Code 6f. Other

Next of Kin/Emergency Contact (*Please indicate best method(s) of contact by checking the appropriate box(es).*) (Optional)

7a. Mailing Address, City, State, Zip Code Same address as above 7b. Relationship (*Optional*)

Name 7c. Primary Phone Number (*Optional*)

Street Address 7d. Alternate Phone Number (*Optional*)

City State Zip Code 7e. E-mail Address (*Optional*)

Section II: Requested Coast Guard Credential(s)
Credential or Endorsement Type(s) Requested:

Endorsement Category	Transaction Type (<i>Check all that apply: See instructions for definitions and additional requirements for the transaction below</i>)					
	Original	Renewal	Duplicate	Raise of Grade, New Endorsement or Increase in Scope	Certificate of Registry	Document of Continuity
Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified Rating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
STCW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Entry Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Description of Endorsement(s) Desired: Include all appropriate information - Officer (*i.e. Deck - Master/Mate/Propulsion/Tonnage/Route OR Engineer Grade - 3rd AE; DDE/Propulsion/Horsepower*) Ratings (*i.e.: Able Seaman, Tankerman, QMED, Lifeboatman*) (**Please Print**)

FOR RENEWAL TRANSACTIONS ONLY: I request to waive the post-dating feature and to have my merchant mariner credential (MMC) issued immediately. I decline having its issuance coincide with the expiration date of my current credential.

APPLICATION FOR MERCHANT MARINER CREDENTIAL (FORM CG-719B)

Section III: Safety and Suitability

1. **TWIC (Transportation Worker's Identification Credential) EXEMPTION STATEMENT** - I have previously applied for a TWIC with TSA and I am exempt from holding a valid TWIC under Coast Guard Policy Letter 11-15. I understand that a name based safety and suitability check could significantly delay the processing of my Merchant Mariner Credential Application.

2. **Criminal Record (Convictions and Drug Use):** If you answer Yes to ANY of the questions below you must disclose the information regarding the conviction. You may complete the optional form CG-719C for each question marked "Yes".

- a) Have you ever been a user of/or addicted to a dangerous drug, including marijuana, within the last 10 years? Yes No
- b) Have you ever been convicted of violating a dangerous drug law of the United States, District of Columbia, or any state, or territory of the United States? Yes No
- c) Have you ever been convicted by any court-including military court - for an offense other than a minor traffic violation? Yes No
- d) Have you ever been convicted of a traffic infraction arising in a connection with a fatal traffic accident, reckless driving or racing on a highway or operating a motor vehicle while under the influence of, or impaired by, alcohol or a controlled substance? Yes No
- e) Have you ever had your driver's license revoked or suspended for refusing to submit to an alcohol or drug test? Yes No
- f) Have you had a drug test with a result other than negative within the last 10-years? Yes No

3. **National Driver Registry (NDR) Consent (Mandatory for Original, Renewal, or new Officer Endorsement):** I authorize the National Driver Registry to furnish the U.S. Coast Guard (USCG) information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. **NOTE: Not required for Document of Continuity applicants.**
I understand the USCG will make the information received from the NDR available to me for review and written comment prior to disapproving my application or taking any action against my Merchant Mariner's Credential. Authority: 46 U.S.C. 710(g), 46 U.S.C. 7302(c), and 46 U.S.C. 7505.

Section IV: Mariner's Consent/Certification

1. **Mariner Outreach System (Optional):** I consent to voluntary participation in the Mariner Outreach System to be used by the Maritime Administration (MARAD) in the event of a national emergency or sealift crisis. In such an emergency, MARAD would disseminate my contact information to an appropriate maritime employment office to determine my availability for possible employment on a sealift vessel. Once consent is given, it remains effective until revoked either by subsequent application or by sending a signed notice of revocation to the U.S. Coast Guard National Maritime Center, 100 Forbes Dr., Martinsburg, WV 25404. For more information, please visit <https://mos.marad.dot.gov/>.

- Yes, I would like to participate No thanks, I do not wish to participate at this time

2. FOR CONTINUITY RENEWAL ONLY

I understand that a Document of Continuity is not valid for use in accordance with 46 CFR 10.227 and aware of the requirements to obtain an MMC. STCW endorsements may not be placed in continuity per 46 CFR 10.227.

3. **CONSENT:** I am under 18 years of age and a notarized statement of parental/guardian consent is attached.

4. Certification

My signature below attests that:

- All information on this application is true and correct to the best of my knowledge.
- I understand an application determined to be fraudulent may result in the denial of my application for one year from the date of submission, even if the fraudulent information was not by itself cause for denial or prosecution.
- I do solemnly swear or affirm that I will faithfully and honestly, according to my best skill and judgment, and without concealment and reservation, perform all the duties required of me by the laws of the United States. I will faithfully and honestly carry out the lawful orders of my superior officers aboard a vessel.

5. Applicant's Signature

Signature of Applicant

X _____

Date (MM/DD/YYYY)

Signature of individual authorized to administer the Oath. This is required only once for a mariner.

X _____

Date (MM/DD/YYYY)

Name of individual authorized to administer the Oath: _____

APPLICATION FOR MERCHANT MARINER CREDENTIAL (FORM CG-719B)

Section IV: Mariner's Consent/Certification (continued)

6. Third Party Authorization (Optional)

- I understand that by checking boxes 6a - 6d in Section IV, I authorize release of information, MMC, or authority to act on my behalf to the third party indicated until issuance of a MMC or until Agency final action is made.

6a. Safety and Suitability

Name of Organization or Third Party

6b. Professional qualifications, certification records, training records, or Sea Service

Organization Point of Contact (if applicable)

6c. Merchant Mariner Credential Delivery

Street Address

6d. Act on my behalf in all matters pertaining to the processing of my current USCG credential application (All of the above)

City

State

Zip Code

Phone Number

Email Address

Signature of Applicant

X

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. 10.209.

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).

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, and any endorsement within the MMC.

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 report is 9 minutes. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Chief, Office of Merchant Mariner Credentialing, 2703 Martin Luther King, Jr. Ave, S.E., STOP 7509, Washington, D.C., 20593-7509 or Office Of Management and Budget, Paperwork Reduction Project (1625-0040), Washington, DC 20503.

DISCLOSURE STATEMENT FOR NARCOTICS, DWI/DUI, AND/OR OTHER CONVICTIONS (OPTIONAL FORM CG-719C)

----- Instructions -----

Who should submit this form?

Original Merchant Mariner Credential (MMC) applicants are required to list all convictions including military court martial, driving related convictions other than minor traffic violations, and foreign court convictions. For renewals and endorsements, list all of those convictions not previously reported to the Coast Guard on a MMC application. If you are unsure what you previously reported, you are encouraged to provide a complete list of all convictions. Failure to report convictions will delay your credential and may result in denial. You may use this form for the disclosure required by 46 CFR 10.211 to report your convictions, or you may use this form as a guide to provide your written explanation.

If an applicant applies before the minimum assessment period for his or her conviction, he or she must submit evidence of suitability for service. This may include: proof of completion of alcohol or drug abuse rehab; membership in a rehab or counseling group; character references; steady employment; and successful completion of parole or probation. 46 CFR 10.211(i)

CONVICTION DEFINED (46 CFR 10.107)

A. An applicant **will be** considered to have **received a conviction** of a criminal **Felony, Misdemeanor** or a **National Driver Register (NDR)** offense if he or she:

1. Was **Found Guilty, or Pleaded Guilty**,
2. Pleaded **No Contest**,
3. Was granted **Deferred Adjudication**,
4. Was **Required** to:
 - (a) **Attend Classes**,
 - (b) **Make** contributions of **Time** or **Money**,
 - (c) **Receive Treatment**,
 - (d) **Submit** to any manner of **Probation** or **Supervision**, or,
 - (e) **Forego Appeal** of a trial court's conviction.

B. A conviction of more than one offense at a single trial will be considered to be **multiple** convictions.

C. **Expunged** convictions must be reported unless the expungement was based upon a showing that the court's earlier conviction was in error.

Section I: Applicant Information

- **Legal Name** - Enter complete legal name and include aliases used and/or maiden name(s).
- **Reference Number** - If you have been credentialed by the Coast Guard in the past, enter your reference number.
- **Social Security Number** - If you are applying for an original credential, enter your SSN.
- **Date of Birth** - If applicant is under 18 years of age, notarized statement from legal guardian is required.

Section II: Conviction and/or Drug Use Disclosure

- **Convicted of** - Enter the exact charge(s) for which you were convicted.
- **City** - Enter the city/town/parish where you were convicted.
- **State/Country** - Enter the state/country where you were convicted.
- **Date** - Enter the date of conviction.
- **Court findings** - Enter the court's final determination of charges to include amended or added charges.
- **Court sentence/requirements** - Enter length of an incarceration ordered by court, probation (probation officer name and phone number), fines, classes, driving privilege suspended/revoked and reinstatement date, etc.)
- **What happened** - Provide brief description of events leading to arrest to include the Arresting Agency.

Section III: Acknowledgment and Certification

- **Signature of Applicant** - Acknowledge that you have read and understand the definition of conviction and certify that the information on this Disclosure Statement for Narcotics, DWI/DUI, and/or other Convictions form is true and correct.
- **Date** - Enter current date.

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. 10.211

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).

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 and any endorsement within the MMC.

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 completing this form is 10 minutes. You may submit any comment concerning the accuracy of this burden estimate 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.

DISCLOSURE STATEMENT FOR NARCOTICS, DWI/DUI, AND/OR OTHER CONVICTIONS (OPTIONAL FORM CG-719C)

Section I: Applicant Information (Please Print)

1. Legal Name	Last	First	Middle	Alias(es) or Maiden Name(s) (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Reference Number	3. Social Security Number (000-00-0000)		4. Date of Birth (MM/DD/YYYY)	
<input type="text"/>	<input type="text"/>		<input type="text"/>	

Section II: Conviction and/or Drug Use Disclosure (Please Print)

Failure to disclose the details requested below for every question marked YES in Section III of the CG-719B will delay the application process. **Please attach additional sheets as necessary.**

DANGEROUS DRUG USE DETAILS (if any)	5. Type of Drug	6. Month/Year of Last Use (MM/YYYY)
	<input type="text"/>	<input type="text"/>

CONVICTION DETAILS CONVICTION 1

a. Convicted of	b. City	c. State/Country	d. Date (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Court findings: (deferred adjudication, guilty plea/no contest, etc.)	f. Court sentence/requirements: (length of any incarceration ordered by court, probation [probation officer name and phone number], fines, classes, driving privilege suspended/revoked, and reinstatement date, etc.)		
<input type="text"/>	<input type="text"/>		
g. What happened and did you comply with/are you in compliance with court order (Provide brief description of events and Arresting Agency)			
<input type="text"/>			

CONVICTION 2

a. Convicted of	b. City	c. State/Country	d. Date (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Court findings: (deferred adjudication, guilty plea/no contest, etc.)	f. Court sentence/requirements: (length of any incarceration ordered by court, probation [probation officer name and phone number], fines, classes, driving privilege suspended/revoked, and reinstatement date, etc.)		
<input type="text"/>	<input type="text"/>		
g. What happened and did you comply with/are you in compliance with court order (Provide brief description of events and Arresting Agency)			
<input type="text"/>			

Section III: Acknowledgment and Certification

I acknowledge that I have read and understand the definition of "conviction" in the instructions, and I certify that the information on this Disclosure Statement for Narcotics, DWI/DUI, and or Other Convictions form is true and correct.

Signature of Applicant

Date (MM/DD/YYYY)

<input type="text"/>	<input type="text"/>
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DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard
DOT/USCG PERIODIC DRUG TESTING FORM (OPTIONAL CG-719P)

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

Who must submit this form?

INSTRUCTIONS: This form MAY be used to satisfy the requirements for "Periodic Testing Requirements" in accordance with Title 46 CFR 16.220. If you participate in a USCG "random or pre-employment drug test program," this form may not be necessary. (See page 2 for details.)

NOTE: The cost of the drug test is the sole responsibility of the applicant, not the Coast Guard.

Section I: Applicant Consent

I certify that I am the described applicant and that I have provided the specimen(s) described below in accordance with Department of Transportation procedures given in 49 CFR 40. I also understand that making in any way, a false or fraudulent statement, entry, or evidence is a violation of the U.S. Criminal Code at Title 18 U.S.C. 1001 which subjects the violator to federal prosecution and possible incarceration, fine, or both.

Name Last First Middle Reference Number (if applicable) Social Security Number

Signature of Applicant (Required)

Date (MM/DD/YYYY)

X _____

Section II: Name of SAMHSA Accredited Laboratory

Name Street Address City State Zip Code

SECTION III: Medical Review Officer

Date Specimen Collected (MM/DD/YYYY)

The laboratory report has been reviewed in accordance with procedures given in 49 CFR Part 40, Subpart G, and the verified test results are: (CHECK ONE)

Specimen Analyzed For (Drugs identified by 49 CFR 40.85), including:

- NEGATIVE
- CANCELLED or
- Positive, and/or refusal to test because of adulteration or substitution.

(Please complete the next block for all non-negative results)

- Marijuana metabolite
- Cocaine metabolites
- Amphetamines
- Opiate metabolites
- Phencyclidine (PCP)

FOR POSITIVE/ADULTERATED/CANCELLED DRUG TESTS ONLY: (To be reported to the nearest USCG Sector or Unit). (Please print)

This specimen is verified POSITIVE for

This specimen was identified as being SUBSTITUTED or containing an ADULTERANT

The test was CANCELLED because (insert reason)

I certify that I meet qualifications for a Medical Review Officer as outlined in Title 49 CFR 40.121. I have reviewed the results and determined that the applicant's verified test result is in accordance with Title 49 CFR 40 Subpart G.

MEDICAL REVIEW OFFICER CONTACT INFORMATION

MEDICAL REVIEW OFFICER AUTHORITY

Name Last First Middle

Name Last First Middle

Street Address

Signature (MRO signature stamp is authorized for negative results only)

City State Zip Code

Name of MRO Qualifying Organization

Phone: _____

Registration Number Issued by Qualifying Organization: _____

DOT/USCG PERIODIC DRUG TESTING FORM (OPTIONAL CG-719P)

REQUIREMENTS	<ul style="list-style-type: none"> A drug test is required for all transactions EXCEPT endorsements, documents of continuity, duplicates, and STCW certificates. Only a chemical test meeting the requirements of 49 CFR Part 40 will be accepted.
OPTION I PERIODIC TESTING PROGRAM	<ul style="list-style-type: none"> A DOT Chemical test conducted within the past 185 days by a laboratory accredited by Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services. COLLECTION of a sample may be conducted by an independent medical facility, private physician or at an employer-designated site as long as the collection agent meets the qualification requirements to be a collection agent given in Title 49 CFR Part 40 Subpart C. It is CRITICAL that the sample is sent to an accredited SAMHSA laboratory for ANALYSIS or the drug test is invalid. The ORIGINAL results are required. A FACSIMILE is acceptable, if it is originated from the Medical Review Officer (MRO) or the Service Agent assisting the mariner, and sent directly from the office. The drug test result must be signed and dated by the MRO.
OPTION II RANDOM TESTING	<p>EXAMPLE (From Mariner Employers): <i>APPLICANT'S NAME/SSN</i> has been subject to a random testing program meeting the criteria of Title 46 CFR 16.230 for at least 60 days during the previous 185 days and has not failed nor refused to participate in a chemical test for dangerous drugs.</p> <p>EXAMPLE (Active Duty Military/Military Sealift Command/N.O.A.A./Army Corps of Engineers): <i>APPLICANT'S NAME/SSN</i> has been subject to a random testing program with no subsequent positive drug test results during the remainder of the six month period.</p>
OPTION III PRE-EMPLOYMENT TESTING	<ul style="list-style-type: none"> An ORIGINAL DATED letter on mariner employer stationery signed by a company official, stating that they hold evidence that mariner either passed a chemical test for dangerous drugs within the past 185 days or has been subject to a random testing program. <p>EXAMPLE: <i>APPLICANT'S NAME/SSN</i> passed a chemical test for dangerous drugs, required under Title 46 CFR 16.210 within the previous six months of the date of this letter with no subsequent positive drug test results during the remainder of the six month period.</p>

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 CFR 10.209(h) and 16.101.

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).

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, and any endorsement within the MMC.

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 report is 5 minutes. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Chief, Office of Merchant Mariner Credentialing, 2703 Martin Luther King, Jr. Ave, S.E., STOP 7509, Washington, D.C., 20593-7509 or Office of Management and Budget, Paperwork Reduction Project (1625-0040), Washington, DC 20503.

SMALL VESSEL SEA SERVICE FORM (OPTIONAL CG-719S)

For Service on Vessels of Less Than 200 Gross Register Tons Only

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; and 46 CFR Part 10.

PURPOSE: To determine whether an applicant meets the regulatory standards for issuance of a U.S. Merchant Mariner Credential (MMC).

ROUTINE USES: Authorized U.S. Coast Guard (USCG) officials will use this information to determine if an applicant meets the qualifications to be issued a MMC, any endorsement within the MMC, or a medical certificate. Additionally, the USCG will use this information to maintain and update merchant mariner transactions. Any external disclosures of information within this record will be made in accordance with DHS/USCG-030, Merchant Seamen's Records, 76 Federal Register 66933 (June 25, 2009).

CONSEQUENCES OF FAILURE TO PROVIDE INFORMATION: Providing this information is voluntary (including your Social Security number (SSN)). However, failure to provide this information may result in the non-issuance of the MMC.

Section I: Applicant Information (Note: Complete One Form Per Vessel)

Name Last	First	Middle	Reference Number (if applicable)	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Vessel Name	Official number(s) listed on the registration, certificate, or document
<input type="text"/>	<input type="text"/>

Vessel Gross Tons	Length Feet	Inches	Width (if known) Feet	Inches	Depth (if known) Feet	Inches
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Propulsion (Motor/Steam/Gas Turbine/Sail/Aux Sail)	Served As (Master/Mate/Operator/Deckhand/Engine etc.)
<input type="text"/>	<input type="text"/>

Name of Body or Bodies of Water Upon Which Vessel was Underway (Geographic Locations)

Section II: Record of Underway Service

In the block under the appropriate month, write in the number of days you served for that year (you can show more than one year)

January		February		March		April	
Year	Days	Year	Days	Year	Days	Year	Days
May		June		July		August	
Year	Days	Year	Days	Year	Days	Year	Days
September		October		November		December	
Year	Days	Year	Days	Year	Days	Year	Days

Total number of days served on this vessel:	<input type="text"/>	Number of days served on Great Lakes:	<input type="text"/>
Average hours underway (per day)?	<input type="text"/>	Number of days served on waters shoreward of the boundary line as defined in 46 CFR Part 7:	<input type="text"/>
Average distance offshore:	<input type="text"/>	Number of days served on waters seaward of the boundary line as defined in 46 CFR Part 7:	<input type="text"/>

SMALL VESSEL SEA SERVICE FORM (OPTIONAL CG-719S)

Section III: Signature and Verification - Applicant Read Before Signing!

- Owners of vessels may attest to their own experience and provide proof of ownership per 46 CFR 10.232.
- Those who do not own their own vessel must obtain letters or other evidence from licensed personnel or the owners of the vessels listed per 46 CFR 10.232.

I certify that I have served on the above vessel as stated. I am making this statement in order that I, the applicant, may obtain a credential to operate a vessel under the provisions of Title 46 CFR, as applicable. I understand that if I make any false or fraudulent statement in this certification of service, I may be subject to a fine or imprisonment of up to five (5) years or both (18 U.S.C. 1001).

Signature of Applicant

X

Date (MM/DD/YYYY)

Owner, Operator or Master Read Before Signing! I certify that the above individual has served on the above vessel as stated. I am making this statement in order that the applicant may obtain a credential to operate a vessel under the provisions of Title 46 CFR, as applicable. I understand that if I make any false or fraudulent statement in this certification of service, I may be subject to a fine or imprisonment of up to five (5) years or both (18 U.S.C. 1001).

Signature and Title of Person Attesting to Experience

X

Date (MM/DD/YYYY)

Owner's, Operator's, or Master's Name

Last

First

Middle

Owner's, Operator's, or Master's address and phone number

Street Address

Email Address (Optional)

City

State

Zip Code

Phone

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 report is 15 minutes. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Chief, Office of Merchant Mariner Credentialing, 2703 Martin Luther King, Jr. Ave, S.E., STOP 7509, Washington, D.C., 20593-7509 or Office of Management and Budget, Paperwork Reduction Project (1625-0040), Washington, DC 20503.

APPLICATION FOR MEDICAL CERTIFICATE

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.

----- 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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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.
- **Sex** - Enter 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 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 Merchant Mariner Medical Manual which can be found at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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. 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)

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

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

APPLICATION FOR MEDICAL CERTIFICATE

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

Last Name	First Name	Middle Name	Suffix (<i>Jr., Sr., III</i>)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mariner Reference Number or Social Security Number	Sex:	Date of Birth (MM/DD/YYYY)	
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	

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

Home Address (PO Box NOT acceptable) <input type="checkbox"/>	Primary Phone Number <input type="checkbox"/>		
Street Address	<input type="text"/>		
<input type="text"/>	<input type="text"/>		
City	State	Zip Code	Alternate Phone Number <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Delivery/Mailing Address, if different (PO Box acceptable) <input type="checkbox"/>	E-mail Address <input type="checkbox"/>		
Street Address	<input type="text"/>		
<input type="text"/>	<input type="text"/>		
City	State	Zip Code	Other <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

- 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.
- 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.
- 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:
 - 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.
 - 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.
 - 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 Merchant Mariner Medical Manual, located at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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

- 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**
- 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

- Medical Practitioner must verify applicants medications and information listed in the table below.
- 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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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	<input type="checkbox"/>	<input type="checkbox"/>	7. Upper/Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	13. Skin	<input type="checkbox"/>	<input type="checkbox"/>
2. Eyes/Pupils/EOM	<input type="checkbox"/>	<input type="checkbox"/>	8. Spine/Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	14. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
3. Mouth and Throat	<input type="checkbox"/>	<input type="checkbox"/>	9. Vascular System	<input type="checkbox"/>	<input type="checkbox"/>	15. Mental Status	<input type="checkbox"/>	<input type="checkbox"/>
4. Ears/Drums	<input type="checkbox"/>	<input type="checkbox"/>	10. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>		No	Yes
5. Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>	11. General/Systemic	<input type="checkbox"/>	<input type="checkbox"/>	16. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart	<input type="checkbox"/>	<input type="checkbox"/>	12. Extremities/Digit	<input type="checkbox"/>	<input type="checkbox"/>			

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://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.PDF.

a. Visual Acuity

Distance Vision, Uncorrected: If correction required, Distance Vision Correctable To:

Right: 20/ | Right: 20/
Left: 20/ | Left: 20/

Field of Vision

- Normal (the applicant's horizontal field of vision is greater than or equal to 100 degrees).
 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) Ishihara pseudoisochromatic plates test, 14 plate (5 or less errors)
 AOC-HRR (2nd Edition) - (No errors in test plates 7-11) Ishihara pseudoisochromatic plates test, 24 plate (6 or less errors)
 HRR PIP (4th Edition) - (No errors in test plates 5-10) Ishihara pseudoisochromatic plates test, 38 plate (8 or less errors)
 Richmond (2nd and 4th Edition) - (6 or fewer errors) Farnsworth Lantern (colored lights) Test per instruction booklet
 Titmus Vision Tester/OPTEC 2000 - (No errors on 6 plates) Dvorine (2nd Edition) pseudoisochromatic 15 plate test (6 or less errors)
 OPTEC 900 (colored lights) Test per instruction booklet

- 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 \geq 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 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. 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:** _____

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

<i>Shipboard Tasks, Function, Event, or Condition</i>	<i>Related Physical Ability</i>	<i>The Examiner Should Be Satisfied That The Applicant:</i>
Routine movement on slippery, uneven, and unstable surfaces	Maintain balance (<i>equilibrium</i>)	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 (<i>lowering height by bending knees</i>); kneel (<i>placing knees on ground</i>); stoop (<i>lowering height by bending at the waist</i>); use hand tools such as span-ners, 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 (<i>ability to move body using hands and knees</i>); feel (<i>ability to handle or touch to examine or determine differences in texture and temperature</i>)	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 Merchant Mariner Medical Manual which can be found at https://media.defense.gov/2019/Sep/11/2002181050/-1/-1/0/CIM_16721_48.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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature	Date (MM/DD/YYYY)	Phone Number	MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Office Street Address	<i>(Place office address stamp here)</i>
<input type="text"/>	
City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>	

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)
<input type="text"/>	<input type="text"/>

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.

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

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.

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)