NNPC

Noord
Nederlandsche
P&I Club

AUTHORIZATION FOR MEDICAL TREATMENT FORM

VESSEL INFORMATION

Vessel:_____ Master:_____ Shipowner: _____

Agent: _____ Port:_____

CREW MEMBER INFORMATION

Full Name:_____

Date of Birth:_____ Address:_____ Rank:_____

Nationality:_____ Passport:_____ ID No.:_____

Medical complaint: _____

INCIDENT REPORT

Incident: _____

_____

_____

_____

_____

Witnesses: _____

_____

Reason for treatment: _____

_____ _____ _____ _____

Physician/Hospital (printed name) Address City Country

_____ _____

Telephone/ E-mail **Signature Master**

Date:_____

Please submit this form to the Owners before treatment is arranged.

CREW MEMBER'S DECLARATION

I, ……., hereby confirm that the contents of this Form are true and correct. I hereby give permission for any personal or medical information and reports obtained as part of my treatment to be disclosed to the Owners, their insurers and/or any medical representatives for purposes of my medical treatment, repatriation and/or rehabilitation and that such information and reports may be retained for this purpose for a period of up to 24 months after I have been declared Fit to Work or a final determination of disability has been made.

_____

Signature Crew Member

Date: _____