



Please complete this health questionnaire. We are only concerned in establishing that you are medically fit enough to perform occasionally rigorous crew duties without risk to your health. In this context, any omissions on your part may be detrimental to you. Information given is strictly confidential and will not be released to any person outside the Station and Regional Head Office without your signed permission.

If you withhold medical information it may later invalidate your insurance coverage that we provide at no charge through RCM-SAR.

Please check **YES** or **NO** and give approximate dates and brief explanation to help us make our best decision regarding your application for membership.

**Have you had, or do you have...**

	YES	NO	PLEASE PROVIDE DATE AND DETAILS FOR ANY CONDITIONS MARKED YES
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sea Sickness	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes (Type 1 or 2)	<input type="checkbox"/>	<input type="checkbox"/>	
Major Injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	

**PLEASE DESCRIBE ANY PAST OR CONTINUAL MEDICAL OR PHYSICAL CONDITIONS NOT  
SELECTED ABOVE:**

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In the event that there is concern whether RCM-SAR Station activities could impact your health, would you be willing to undertake a marine medical evaluation (now or in the future) at our expense?

YES NO

☐ ☐

Date: \_\_\_\_\_  
mm-dd-yyyy

Signature: \_\_\_\_\_  
*by typing your name in this signature box you are legally signing this document*