
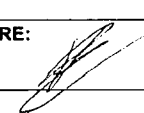


PEME / REME FORM A

(Pre-Employment & Re-Employment Medical Examination Form)

This seafarer medical certificate complies with STWC 1/9 or ILO-73 Panama & Maltese medical standards or as approved by countries with a reciprocal recognition agreement, "Guidance for conducting medical fitness examination for seafarers."

SEAFARER DECLARATION					
First Name: VEDRAN		Last Name: BILONIC		Nationality: CROATIAN	
				Country of residence: CROATIA	
Gender: Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> (if other, please state in comments)		Date of Birth: 08.03.1996		Crew Position: SHORE EX STAFF	
		Crew ID:		Passport Number: 270671465	
				Vessel:	
				Seaman's Book Number: 00086079	
Do you or have you ever had any of the following?		Yes	No	Do you or have you ever had any of the following?	
				Yes	No
1. Severe headaches or nosebleeds		<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Skin problems/rashes	<input type="checkbox"/> <input checked="" type="checkbox"/>
2. Head injury/concussion/memory loss		<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Allergies to environment, chemicals, food or drugs	<input checked="" type="checkbox"/> <input type="checkbox"/>
3. Fainting/seizures/epilepsy/stroke/TIA		<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. Joint pains/arthritis/numbness in extremities	<input type="checkbox"/> <input checked="" type="checkbox"/>
4. Eye injury/eye problems/wear glasses/contact lenses		<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. <u>Fracture</u> /dislocation /injury/amputation/prosthesis	<input checked="" type="checkbox"/> <input type="checkbox"/>
5. Ear problems/frequent ear infections/hearing aids		<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Neck/back pain or injury/restricted mobility	<input type="checkbox"/> <input checked="" type="checkbox"/>
6. Frequent colds/sinus trouble		<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. Serious accidents/illnesses	<input type="checkbox"/> <input checked="" type="checkbox"/>
7. Poor circulation/varicose veins		<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. Malignant diseases/cancer/tumours	<input type="checkbox"/> <input checked="" type="checkbox"/>
8. Asthma/bronchitis/pneumonia/tuberculosis		<input type="checkbox"/>	<input checked="" type="checkbox"/>	26. Breast lumps/masses/tenderness	<input type="checkbox"/> <input checked="" type="checkbox"/>
9. Breathing problems/wheezing/coughing up blood		<input type="checkbox"/>	<input checked="" type="checkbox"/>	27. Syphilis/HIV/gonorrhoea/chlamydia	<input type="checkbox"/> <input checked="" type="checkbox"/>
10. High/low blood pressure/heart disease/heart attack		<input type="checkbox"/>	<input checked="" type="checkbox"/>	28. Yellow fever/scarlet fever/malaria/tropical diseases	<input type="checkbox"/> <input checked="" type="checkbox"/>
11. Shortness of breath/chest pain/palpitations/angina		<input type="checkbox"/>	<input checked="" type="checkbox"/>	29. Mental illness/depression/anxiety/sleep disorder	<input type="checkbox"/> <input checked="" type="checkbox"/>
12. Abdominal pain/hernias/hydrocele/appendicitis		<input type="checkbox"/>	<input checked="" type="checkbox"/>	30. Varicella/measles/mumps/hepatitis (A, B or C)	<input type="checkbox"/> <input checked="" type="checkbox"/>
13. Jaundice/liver disease/gallbladder problems		<input type="checkbox"/>	<input checked="" type="checkbox"/>	31. Any medical conditions not mentioned on this form	<input type="checkbox"/> <input checked="" type="checkbox"/>
14. Gastritis/reflux/gastric or duodenal ulcers		<input type="checkbox"/>	<input checked="" type="checkbox"/>	32. Prostate problems (for males)	<input type="checkbox"/> <input checked="" type="checkbox"/>
15. Stomach problems/frequent diarrhoea/constipation		<input type="checkbox"/>	<input checked="" type="checkbox"/>	FOR FEMALES	
16. Haemorrhoids/rectal bleeding/bowel problems		<input type="checkbox"/>	<input checked="" type="checkbox"/>	33. Are you or do you think you may be pregnant?	<input type="checkbox"/> <input type="checkbox"/>
17. Diabetes/thyroid problems		<input type="checkbox"/>	<input checked="" type="checkbox"/>	34. When was your last menstrual period? (DD/MM/YY)	<input type="checkbox"/> <input type="checkbox"/>
18. Frequent urinary/kidney infections/blood in urine		<input type="checkbox"/>	<input checked="" type="checkbox"/>	35. Gynaecological problems/cysts	<input type="checkbox"/> <input type="checkbox"/>
TO BE FILLED OUT BY THE PHYSICIAN. If "yes" to any of the above questions, please give details:					
22. Fracture of right elbow			20. Spring flowering allergy		
Additional questions					
Have you ever been hospitalised or had any type of surgery?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	When? AGE 4 What for? TONSILS	
Has your medical certificate even been restricted/revoked?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	When? What for?	
Are you taking any non-prescription/prescription medications?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	What? What for?	
Have you ever received a blood transfusion?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	When? What for?	
Have you ever been signed off sick or repatriated from a ship?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	When? What for?	
Do you or have you ever smoked?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	How many per day? When did you quit?	
Do you drink alcohol?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	How many units per day? Per week?	
FOR PHYSICIAN. I confirm that I have reviewed the above information with the applicant and noted comments as required.			FOR SEAFARER. My signature below acknowledges that all statements provided by me in this application are true and correct to the best of my knowledge and belief. I authorise and consent to the release of my medical records from any source, including nations, insurance offices, doctors, hospitals and/or other institutions of public authorities. This general medical release will also authorise the release of my psychological/psychiatric records/referrals. I UNDERSTAND THAT FALSIFICATION WILL BE GROUNDS FOR LOSS OF BENEFITS AND/OR TERMINATION OF EMPLOYMENT. My signature acknowledges my consent to any physical examinations and diagnostic testing.		
PHYSICIAN NAME: MILENA MATULIC		REGISTRATION NUMBER: 46/43			
PHYSICIAN EMAIL ADDRESS: ustanova.matulic@gmail.com		PHYSICIAN PHONE NUMBER: +385 21 266 006			
PHYSICIAN SIGNATURE: 		DATE: 14.04.2022		SEAFARER SIGNATURE: 	
				DATE: 14.04.2022	

ORIGINAL COPY TO BE TAKEN TO SHIP'S MEDICAL CENTRE

Page 1 of 1

 dr. MILENA MATULIĆ
 ZA DJELATNOST MEDICINE RADA
 za Domovinskog rata 45. 21000 Split



RE-EMPLOYMENT & SHIPBOARD EMPLOYEE MEDICAL EXAM FORM B

(for returning crew)

This Seafarer Medical Certificate complies with STWC 1/9 or ILO-73, Panama and Maltese Medical Standards or as approved by Countries with a Reciprocal Recognition Agreement, "Guidance for conducting Medical Fitness Examination for Seafarers"

Last Name: BILONIC First Name: VEDRAN Birth Date (mm/dd/yy): 8.9.1996 Exam Date: 11.04.2022
 Temp: 36.2 Pulse: 54 Resp: 14 B/P: 120/80 Height: 205 Weight: 85 Body Mass Index (BMI): 20.2

Chest X-Ray <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Other	Field Vision R = WNL <input checked="" type="checkbox"/> L = WNL <input checked="" type="checkbox"/>	Colour Vision <input checked="" type="checkbox"/> Ishihara <u>NORMAL</u> <input checked="" type="checkbox"/> Bostrom Kugelberg <input checked="" type="checkbox"/> Snellen <u>NORMAL</u> <input checked="" type="checkbox"/> Passed <input type="checkbox"/> Not Passed	Vision adequate for position as per standards? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
---	---	--	--

EAR	500hz	1000hz	2000hz	3000hz	4000hz	6000hz	8000hz	Whisper Test: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If ABNORMAL, perform audiogram Information on the use of hearing protection provided? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Any subjective signs of impaired hearing or dizziness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Right	30	30	30	30	30	30	30	
Left	30	30	30	30	30	30	30	

Name of Vaccination	Date of last vaccination	Name of Vaccination	Date of last vaccination	REQUIRED TESTS - Attach ALL LAB TESTS to Original All results must be in ENGLISH			
Diphtheria	17.11.2014	Polio	17.11.2014	VDRL/RPR/FTA (use one)	O&P + Stool Culture (All Food, Beverage and Housekeeping positions)	Comprehensive Metabolic Panel	
Tetanus	17.11.2014	Varicella		CBC (complete blood count)	Hepatitis AlgM, HBsAg & Anti HCV	Lipid Panel	
Typhoid		MMR	12.6.2003	Routine Urinalysis	Urine Drug Test (Benzodiazepines, Amphetamines, THC, Opiates, Cocaine, Barbiturates)	Electrocardiogram	
Pertussis	20.11.2000	Hepatitis A(B)	13.3.2009	Results requiring investigation			
Yellow fever		Tuberculosis	17.12.2004	RT-PCR SARS-CoV2 Swab			
SARS CoV2	When Available		6.4.2021				

PHYSICAL EXAM											
HEENT	Normal	Abnormal	THORAX LUNGS	Normal	Abnormal	ABDOMEN	Normal	Abnormal	RECTAL	Normal	Abnormal
Mouth	✓		Percussion	✓		Shape	✓		Haemorrhoid	✓	
Tonsils	✓		Auscultation	✓		Tenderness	✓		Prostate	✓	
Pharynx	✓		EXTREMITIES			Masses	✓		Fistula	✓	
Ears	✓		Varicose veins	✓		Scars	✓		NECK		
Eyes	✓		Oedema	✓		Hernia	✓		Nodes	✓	
Head	✓		Scars	✓		Circumcised	✓		Motion	✓	
Nose	✓		Discolouration	✓		Testicles	✓		Thyroid	✓	
EMOTIONAL			Deformities	✓		PELVIC			CoV2		
Status	✓		NEURO			Status	✓		Fever		
HEART			Motor	✓		BREASTS			Chills		
Rhythm	✓		Sensory	✓		Tenderness	✓		Muscle Pain		
Murmurs	✓		Reflexes	✓		Masses	✓		Headache		
									Sore Throat		
									Loss of Taste or Smell		

RANGE OF MOTION											
CERVICAL	Normal	Abnormal	ELBOW	Normal	Abnormal	LUMBAR	Normal	Abnormal	WRIST	Normal	Abnormal
Forward flex	✓		Retained flex		✓	Forward flex	✓		Pronation	✓	
Extension	✓		Extension	✓		Extension	✓		Supination	✓	
Lateral flexion	✓		Pronation	✓		Lat. Flex	✓		Dorsiflexion	✓	
Rotation	✓		Supination	✓		Rotation	✓		Planar flexion	✓	
Scars	✓		Scars	✓		Sitting rotation	✓		Abduct	✓	
HIP			FEET			Supine rotation	✓		Adduct	✓	
Flexion	✓		Inspection	✓		Scars	✓		KNEE		
Extension	✓		Arch status	✓		SHOULDER			Retained flex	✓	
Abduction	✓		Deformities	✓		Forward elev.	✓		Extension	✓	
Adduction	✓		ANKLE			Backward elev.	✓		Scars	✓	
Internal rotation	✓		Dorsal flex	✓		Abduction	✓				
External rotation	✓		Plantar flex	✓		Adduction	✓				
FINGERS			Inversion	✓		Int. Rotation	✓				
Flexion	✓		Eversion	✓		Ext. Rotation	✓				
Extension	✓		Scars	✓		Scars	✓				

RIGHT ELBOW FC 95°
DUE TO ST POSI FR CAPITUL RADII CLX
CONTRACTURE ARI CUBITUM
MYOSITIS OSSIFICANS

JOB SPECIFIC PERFORMANCE
 Work Restrictions: _____ Yes No Are they able to perform all activities of their job? Yes No

DECISION
 FIT FOR WORK: (crew member is not believed to be suffering from any sickness or physical or mental ailment making him unfit for service or which may endanger the health of the other persons onboard.)
 UNFIT FOR WORK for the following reason(s): _____
 FIT AFTER DEFECT CORRECTED (Describe): _____

SIGNATURE
 BILONIC VEDRAN CREW MEMBER'S SIGNATURE
 MILENA MATULIC 14.4.2022 PHYSICIAN NAME & SIGNATURE DATE
 UL. DOM. RATA 45, SPLIT ADDRESS
 +385 21 266006 PHONE NUMBER

This seafarer medical certificate complies with STWC 1/9 or ILO-73 Panama & Maltese medical standards or as approved by countries with a reciprocal recognition agreement, "Guidance for conducting medical fitness examination for seafarers."

PHYSICAL EXAMINATION								
Height <u>205</u> cm		Weight <u>85</u> Kg		BMI <u>20.2</u>		Systolic BP <u>120</u>		
Temp <u>36.2</u> Celsius		Resp Rate <u>16</u> /min		Pulse <u>54</u> /min		Diastolic BP <u>80</u>		
1. HEENT	Normal	Abnormal	8. RECTAL	Normal	Abnormal	WRISTS...	Normal	Abnormal
Mouth	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Haemorrhoids	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Dorsiflexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Tonsils	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Prostate	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Planer flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pharynx	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Fistula	<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. FINGERS	Normal	Abnormal
Ears	<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. BREAST	Normal	Abnormal	Flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Eyes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tenderness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Head	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Masses	<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. LUMBAR	Normal	Abnormal
Nose	<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. NECK	Normal	Abnormal	Forward flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. CARDIAC	Normal	Abnormal	Nodes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rhythm	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lateral flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Murmurs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. MENTAL	Normal	Abnormal	Rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. RESPIRATORY	Normal	Abnormal	Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sitting rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Percussion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	RANGE OF MOVEMENT			Supine rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Auscultation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. CERVICAL	Normal	Abnormal	18. HIPS	Normal	Abnormal
4. EXTREMITIES	Normal	Abnormal	Forward flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Oedema	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lateral flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abduction	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Scars	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Adduction	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Discolouration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. SHOULDERS	Normal	Abnormal	Internal rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Deformities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Forward elevation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	External rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. NEUROLOGIC	Normal	Abnormal	Backward elevation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	19. KNEES	Normal	Abnormal
Motor	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abduction	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Retained flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sensory	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Internal rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Reflexes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	External rotation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	20. ANKLES	Normal	Abnormal
6. ABDOMINAL	Normal	Abnormal	14. ELBOWS	Normal	Abnormal	Dorsal flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Shape	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Retained flexion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Plantar flexion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Inversion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Masses	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pronation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Eversion	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Scars	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Supination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. FEET	Normal	Abnormal
7. PELVIC	Normal	Abnormal	15. WRISTS	Normal	Abnormal	Inspection	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pronation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Arch status	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Testicles	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Supination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Deformities	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMENTS: EIGHT ELBOW FLEXION 95° DUE TO ST ROOT PR. CAPITULI RADII DEX AA XII CONTRACTUREX ART. CUBITI DEX MYOSITIS OSSIFICANS								



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VISION

GLASSES WORN?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, state type and purpose:						
COLOUR VISION	Normal	Abnormal	FIELD VISION			VISION ADEQUATE FOR POSITION?	
Ishihara test	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Normal	Abnormal	Yes	<input checked="" type="checkbox"/>
Snellen test	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Left eye	<input checked="" type="checkbox"/>	<input type="checkbox"/>	No	<input type="checkbox"/>
Bostrom Kugelberg	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Right eye	<input checked="" type="checkbox"/>	<input type="checkbox"/>		

HEARING

Information on the use of hearing protection provided?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Speech & whisper test (if abnormal perform audiogram)	Normal	<input checked="" type="checkbox"/>	Abnormal	<input type="checkbox"/>
Any subjective signs of impaired hearing or dizziness?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>					
AUDIOMETRY (see report attached)	500hz	1000hz	2000hz	3000hz	4000hz	6000hz	8000hz		
Right Ear	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Left Ear	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

COMMENTS:
LABORATORY TEST RESULTS

COMMUNICABLE DISEASES		OTHER LABS				URINALYSIS / DRUG SCREEN	
HAV (Hepatitis A Virus)	neg (-)	Na (not required for REME)	138	ALT	34	Glucose	neg (-)
HBs Ag (Hepatitis B Virus)	neg (-)	K (not required for REME)	4.6	AST	19	Protein	neg (-)
HCV (Hepatitis C Virus)	neg (-)	Ca (not required for REME)	2.34	Uric Acid	422	Blood	neg (-)
HIV	neg (-)	Cl (not required for REME)	101	Creatinine	80	Cocaine	neg (-)
VDRL (Syphilis) (RPR or TPHA)	NON REACTIVE	Triglycerides	0.6	Total bilirubin	13	Benzodiazepines	neg (-)
TB Screening (choose one)		Cholesterol LDL	2.1	BUN	6.75	Opiates	neg (-)
Immunoassay		Cholesterol HDL	1.2	Hb (g/dl)	157	Barbiturates	neg (-)
Tuberculin test	5x3 mm	Total Cholesterol	3.6	CBC	5.18	Marijuana	neg (-)
Serial sputum		Glucose (mg/dl)	4.7	HbA1c (only if diabetic & glucose is abnormal)		Amphetamines	neg (-)
Stool for ova and parasites (for all food, beverage and accommodation positions)				Stool culture (for all food, beverage and accommodation positions)			

OTHER TESTS (attach reports)

CHEST X-Ray (attach report)	Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Note:
Electrocardiogram (attach report)	Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Note:
Spirometry (attach report)	Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Note:

Rev 07/20

ORIGINAL FORM AND COPY TO BE PRESENTED TO SHIP'S MEDICAL CENTRE FOR VERIFICATION
 CREW MEMBER WILL RETAIN THE ORIGINAL DURING FULL CONTRACT
 MEDICAL CENTRE WILL RETAIN THE COPY

Page 2 of 5



USTANOVA ZA ZDRAVSTVENU SKRBE
 dr. MILENA MATULIĆ
 ZA DJELATNOST MEDICINE RADA
 Ulica Domovinskog rata 45, 21000 Split

This seafarer medical certificate complies with STWC 1/9 or ILO-73 Panama & Maltese medical standards or as approved by countries with a reciprocal recognition agreement, "Guidance for conducting medical fitness examination for seafarers."

COMMENTS:

VACCINATION RECORD

(Valid vaccination card required for embarkation)

Name of Vaccination	Date of last Vaccination	Name of Vaccination	Date of last Vaccination	Name of Vaccination	Date of last Vaccination
Hepatitis A		MMR	12.06.2003	Diphtheria	17.11.2014
Hepatitis B	19.03.2009	Tetanus	17.11.2014	Pertussis	20.11.2000
Hepatitis C		Tuberculosis	17.12.2004	Yellow Fever	17.06.2016
Varicella		Typhoid		Polio	17.11.2014

HISTORY

Occupational: 4 YEARS OF WORK EXPERIENCE IN TOURISM

Family: NO SIGNIFICANT NOTES

Physiological: NO SIGNIFICANT NOTES

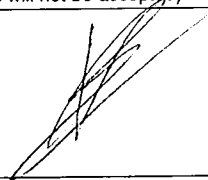

Lifestyle: NO SIGNIFICANT NOTES

Other:

Note:

(for new hires and returning crew)

This seafarer medical certificate complies with STWC 1/9 or ILO-73 Panama & Maltese medical standards or as approved by countries with a reciprocal recognition agreement, "Guidance for conducting medical fitness examination for seafarers."

FINAL ASSESSMENT OF FITNESS FOR SERVICE AT SEA		
Work restrictions?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Note:	
Able to perform all activities of their job?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Note:	
Based on the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically: -		
<input checked="" type="checkbox"/> FIT FOR DUTY (crew member is not believed to be suffering from any sickness, physical or mental ailment making him / her unfit for service or which may endanger the health of any other person onboard)	<input type="checkbox"/> UNFIT FOR DUTY For the following reason(s): -	<input type="checkbox"/> FIT FOR DUTY AFTER DEFECT CORRECTED (Describe): -
CREW MEMBERS DETAILS		
(Forms without CREW MEMBER'S contact details will not be accepted)		
Full Name (please print):	Signature:	
BILONIC VEDRAN		
Address:	Phone number:	
PUJANKE 34 SPUT	+38595 516 64 28	
CLINICIAN DETAILS		
(Forms without physician contact details will not be accepted)		
Full Name (please print):	Signature:	
dr. MILENA MATULIC		
Licence number:	Phone number:	
46143	+38521 266006	
Home address and email:		
ULICA DOM. RATA 45, SPUT ustanova.matulic@gmail.com		
Date medical certificate issued (day/month/year)		Physician Stamp
11, 4, 2022		USTANOVA ZA ZDRAVSTVENU SKRB dr. MILENA MATULIC ZA DJELATNOST MEDICINE RADA Ulica Domovinskog rata 45. 21000 Split
VALID FOR TWO YEARS FROM DATE OF ISSUE		

Rev 07/20

ORIGINAL FORM AND COPY TO BE PRESENTED TO SHIP'S MEDICAL CENTRE FOR VERIFICATION
CREW MEMBER WILL RETAIN THE ORIGINAL DURING FULL CONTRACT
MEDICAL CENTRE WILL RETAIN THE COPY

Page 4 of 5

USTANOVA ZA ZDRAVSTVENU SKRB
dr. MILENA MATULIC
 ZA DJELATNOST MEDICINE RADA
 Ulica Domovinskog rata 45. 21000 Split

(for new hires and returning crew)

This seafarer medical certificate complies with STWC 1/9 or ILO-73 Panama & Maltese medical standards or as approved by countries with a reciprocal recognition agreement, "Guidance for conducting medical fitness examination for seafarers."

Number: 1278-2022-PBJ2

Date (day/month/year): 11.04.2022

Type of medical examination:

- prior regular supervisory special supervisory:
 acquisition renewal of attestation for category C boat skipper
 acquisition renewal of certificate for yacht commander
 international attestation for boat skipper Res.40.EU other:

After a medical examination performed in accordance with the Rules on Establishing Medical Fitness of Crew Members of Maritime Ships, Boats and Yachts, the following is compliance with the requirement of the STCW Convention 1978, as amended and the Maritime Labour Convention 2006, we issue this:

CERTIFICATE

ON MEDICAL FITNESS A CREW MEMBER OF MARITIME SHIPS, BOATS AND YACHTS
REPUBLIC OF CROATIA

First name, surname, names of father/mother: **VEDRAN BILONIĆ (VINKO)**

Sex: male female

Citizenship: HRV

Date of birth (day/month/year): 08.09.1996

Place and country of birth: SPLIT, Republika Hrvatska

Address of residence: Pujanke 34, Split

Employers name, company and head office:

Maritime service: shore excursion staff

Work post: shore excursion staff

Identity of the person was established on the basis of: ID card, seamens book, boarding approval, passport (underline one of the above documents) No.: 114964977 issued at: PP SPLIT

Declaration of the recognized medical practitioner:

Confirmation that identification documents were checked at the point of examination: YES NO

MEDICAL EXAMINATION

HEIGHT: 205 cm. WEIGHT: 85 kg. BLOOD PRESSURE: 120/80 mmHg.

General appearance: normal

VISION	Right eye	Left eye	HEARING	Right ear	normal	Left ear	normal
Without Glasses	20/60	20/60	Color test type	Book	ok	Lantern	ok
With Glasses	20/20	20/20	Yellow: ok	Red: ok		Green: ok	Blue: ok

Is applicant taking any non-prescription medications? YES NO

Hearing meets the standards in STCW Code, Section A-I/9 YES NO

Visual acuity meets standards in STCW Code, Section A-I/9 YES NO

Color vision meets the standards in STCW Code, Section A-I/9 YES NO

Are glasses or contact lenses necessary to meet the required vision standards? YES NO

Unaided hearing satisfactory: YES NO

Date of the last colour vision test: 11.04.2022

Able to request duty? YES NO

Based on the examinees personal statement, clinical examination, psychological examination and the results of functional and laboratory tests, the examinee was found to be:

- Fit for service a merchant navy ship
 on the deck on engine room
 in GMDSS radio service in other services

- Unfit for service a merchant navy ship
 Temporarily unfit
 on the deck on engine room
 in GMDSS radio service in other services

Fit for:

- without limitation
 with limitation
 assessment of medical fitness was not given because:
 other remarks:

Unfit for:

Temporarily unfit for:

Is the seafarer 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

Place of examination: Split

Date (day/month/year): 11.04.2022

Certification expiry date (day/month/year): 11.04.2024

I hereby confirm that I am acquainted with the contents of my Medical Examination Report confirming that the seafarer has been informed of the content of the certificate and of the right to submit a written complaint with Croatian Institute For Health Protection and Safety at Work.

USTANOVA ZA ZDRAVSTVENU SKRB
dr. MILENA MATULIĆ
ZA DJELATNOST MEDICINE RADA

Stamp
Milena Matulić, dr. med.
specijalist medicine rada i sporta

dr. med. specijalist medicine rada i sporta
Ulica Domovinskog rata 45, 21000 Split

(signature of the examinee in the presence of the authorized occupational medicine specialist)

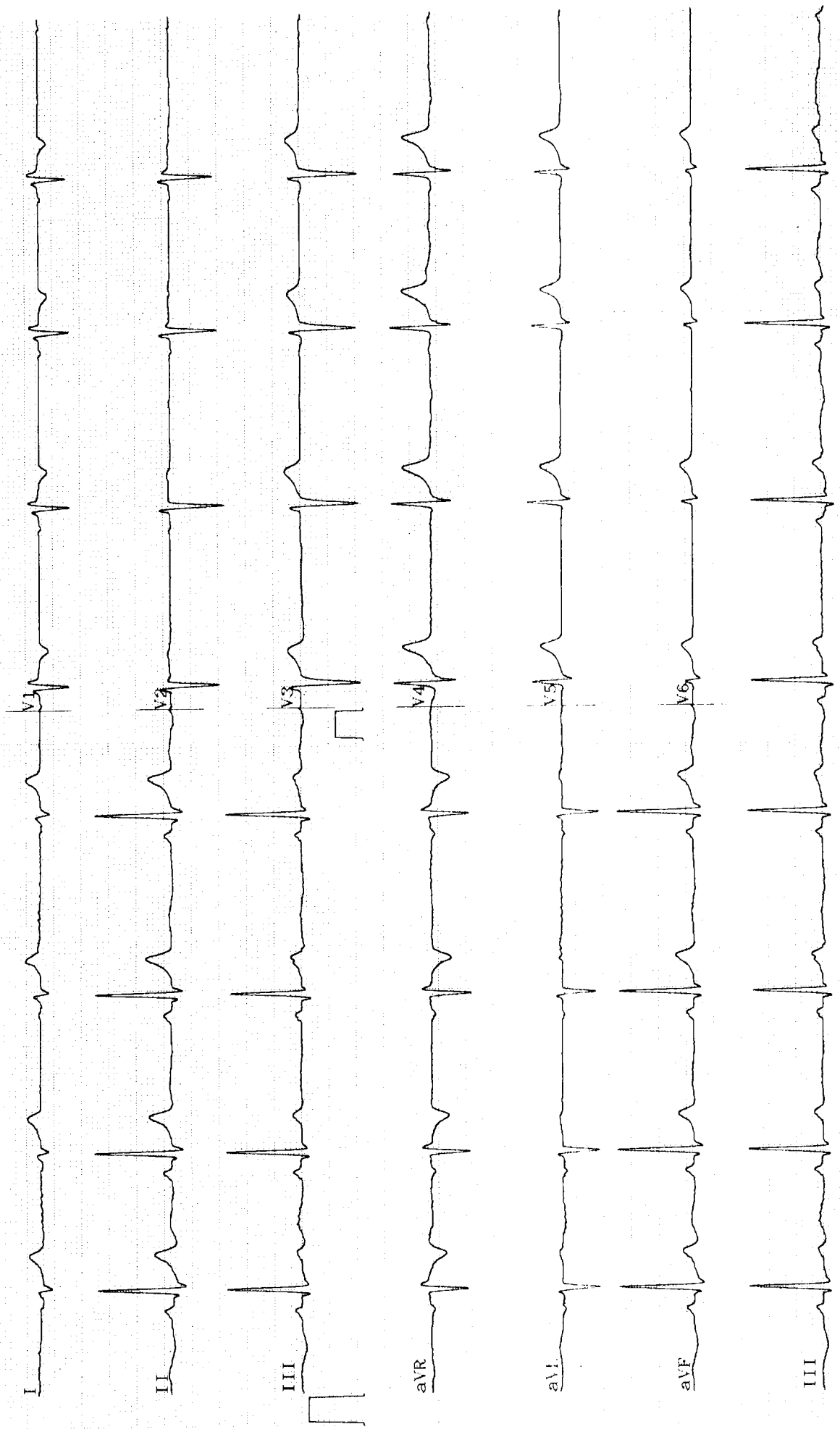
This certificate is issued by authority of Maritime Administrator and is in compliance with the requirements of the Medical Examination (Seafarers) Convention 1978 (ILO No. 73)

*** analysis result *** (10 de libary confirmed by cardiologist)
*** Poor data quality, interpretation may be adversely affected
Sinus Bradycardia
NORMAL AXIS
Borderline Abnormal Ecg

PR Int.: 150ms
QRS Dur.: 112ms
QT/QTc: 392/364ms
P-R-T axes 76 91 60

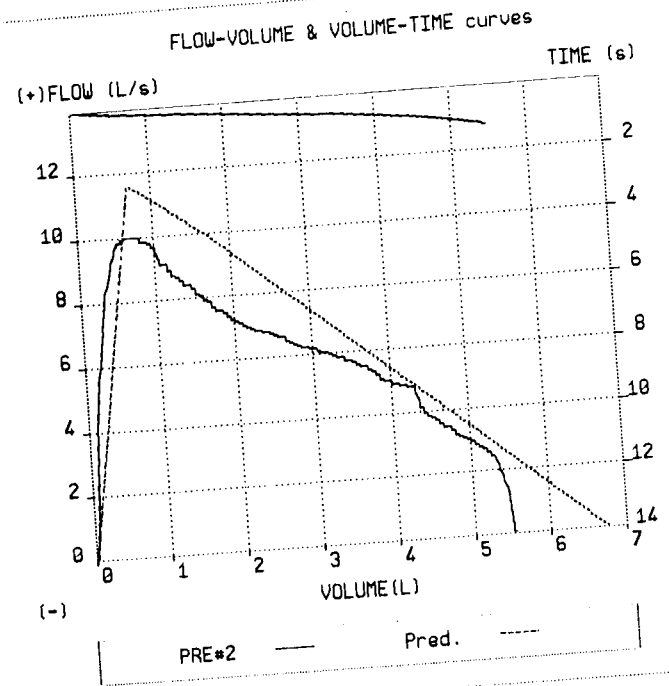
Name: *[Handwritten]*
Age: 25 yrs. / Sex: M
Hei: 205 cm / wei: 85 kg

11.06.2022



Test Date 11/04/2022 12:14 BTPS 1.092 ATS/ERS
 Name bilonic vedran *ID 0011*
 Birth Date 08/09/1996 Weight kg 85 Gender ♂
 Age 25 Height cm 205 Predicted ERS
 Origin Caucasian
 PRE File N° 11

MIR MEDICAL INTERNATIONAL RESEARCH PART NO. 910350



PARAMETER		Predicted	PRE #2	%Pred.
*FVC	L	6.82	6.32	93
*FEV1	L	5.60	5.73	102
*PEF	L/s	11.66	11.19	96
FVC	L	6.82	5.53	81
FEV1	L	5.60	5.45	97
FEV1/FVC	%	82.7	98.6	119
PEF	L/s	11.66	10.13	87
FEF25	L/s	10.00	8.31	83
FEF50	L/s	6.65	6.31	95
FEF75	L/s	3.36	4.82	143
FEF25-75	L/s	5.60	6.32	113
FEF75-85	L/s	1.87	4.08	218
ELA		25		120
EVol	mL	0	127	
FET	s	6.00	1.12	19
PEF Time	ms		67	
FEV0.5	L	4.41	3.74	85
FEV0.5/FVC	%		67.6	
FEV0.75	L		4.81	
FEV0.75/FVC	%		87.0	
FEV3	L	6.48	5.53	85
FEV3/FVC	%	95.0	100.0	105
FEV6	L	6.82	5.53	81
FEV1/FEV6	%	82.1	98.6	120
FEV1/PEF	s	0.48	0.54	113
FEV1/FEV0.5	%	127.0	145.7	115
MVV calc	L/m	186.1	190.8	102

INTERPRETATION:
 Normal Spirometry

QUALITY CONTROL GRADE:F
 EXHALE for a LONGER time
 EXHALE ALL air in the lungs

Ustanova za zdravstvenu skrb dr. Milena Matulić
za djelatnost medicine rada
Split, Ulica Domovinskog rata 45
tel: +38521266006
e.mail: ustanova.matulic@gmail.com

NAME AND SURNAME:	BILONIĆ VEDRAN
DATE OF BIRTH (dd/mm/yy):	08.09.1996
PLACE OF BIRTH (CITY AND COUNTRY):	SPLIT
ADDRESS:	PUJANKE 34
RANK ON BOARD:	SHORE EXCURSION STAFF

BLOOD TESTS

TEST	RESULT
Hepatitis A virus -HAV	NEGATIVE
Hepatitis B virus - HBsAg	NEGATIVE
Hepatitis C virus HCV	NEGATIVE
Human Immunodeficiency virus (HIV)	NEGATIVE
VDRL (SYPHYLIS)	NON - REACTIVE

Signature of applicant:

(This signature should be affixed in the presence of the examining physician)



Date (dd/mm/yy): 11.04.2022

NAME AND DEGREE OF PHYSICIAN: Dr Milena Matulić, M.D., *Occupational Medicine Specialist*

PLACE OF EXAMINATION: Split, Ulica Domovinskog rata 45, CROATIA

SIGNATURE OF PHYSICIAN:



Milena Matulić, dr. med.
specijalist medicine rada i sporta

USTANOVA ZA ZDRAVSTVENU SKRB
dr. MILENA MATULIĆ
ZA DJELATNOST MEDICINE RADA
- Ulica Domovinskog rata 45, 21000 Split



Ustanova za zdravstvenu skrb dr. Milena Matulić za djelatnost medicine rada
Ul. Domovinskog rata 45, 21000 Split; OIB: 32050939559
Tel/fax: 021 266 006; e-mail: ustanova.matulic@gmail.com
www.zdravstvena-skrb-matulic.hr

DRUG / ALCOHOL TEST REPORT

Position applied for: SHORE EXCURSION STAFF

I CERTIFY THAT I AM SAME PERSON BEING TESTED FOR PRESENCE OF DRUG AND ALCOHOL IN MY BLOOD/URINE WHOSE NAME APPEARS ON THIS MEDICAL RECORD AND THAT I HAVE THRUThFULLY ANSWERED THE QUESTIONS ASKED REGARDING MY MY WELL-BEING

Name: BILONIĆ VEDRAN
Address: SPLIT, PUJANKE 34
Age: 25
Weight: 85kg
Height: 205cm

Signature: _____

Date of test: 11.04.3.2022

CERTIFICATION

I CERTIFY THAT LABORATORY EXAMINATIONS ON THE BLOOD/URINE OF APPLICANT USING THE TEST ON THE PRINCIPLE AGGLUTINATION IMMUNOASSAY:

X-DID NOT DETECT PRESEANCE OF PROHIBITED DRUGS

- x ALCOHOL
- x BENZODIAZEPINES
- x AMPHETAMINES
- x COCAINE
- x MARIJUANA -THC
- x OPIATES
- x BARBITURATES

- DETECTED PRESEANCE OF PROHIBITED DRUGS

ALCOHOL
BENZODIAZEPINES
AMPHETAMINES
COCAINE
MARIJUANA -THC
OPIATES
BARBITURATES

MEDICAL TECHNICIAN

USTANOVA ZA ZDRAVSTVENU SKRB
dr. MILENA MATULIĆ
ZA DJELATNOST MEDICINE RADA
Ulica Domovinskog rata 45, 21000 Split

PHYSICIAN

Milena Matulić, dr. med.
specijalist medicine rada i sporta



Medicinsko biokemijski laboratorij
Dom zdravlja splitsko-dalmatinske županije

A. G. Matoša 2, 21000 Split

tel/fax: +385 21 669 515 e-mail: zdravka.doljanin@dz-sdz.hr

NALAZ MEDICINSKO - BIOKEMIJSKOG LABORATORIJA

Ordinacija: Milena Matulić

Laboratorijski broj: 1104**0188

Datum i vrijeme primitka uzorka: 11.04.2022 10:06

Datum validacije: 11.04.2022 11:40

Liječnik

Uzorak uzeo: Milena Matulić

Datum/godina rođenja: 08.09.1996

Spol: M Dob: 26

IME I PREZIME: **VEDRAN BILONIĆ**

LABORATORIJSKA HEMATOLOGIJA

	Rezultat	Jedinica	Ref.interval
(K) Eritrociti	5.18	10 ¹² /L	4.34 - 5.72
(K) Hemoglobin	157	g/L	138 - 175
(K) Hematokrit	0.437	L/L	0.415 - 0.530
(K) MCV	84.5	fL	83.0 - 97.2
(K) MCH	30.3	pg	27.4 - 33.9
(K) MCHC	358 H	g/L	320 - 345
(K) RDW	13.3	%	9.0 - 15.0
(K) Trombociti	201	10 ⁹ /L	158 - 424
(K) MPV	7.1	fL	6.8 - 10.4
(K) Leukociti	4.7	10 ⁹ /L	3.4 - 9.7
(K) Sedimentacija eritrocita	2	mm/3.6 ks	2 - 13

FIZIKALNO KEMIJSKI PREGLED MOKRAĆE

	Rezultat	Jedinica	Ref.interval
(U) Izgled	bistar		bistar
(U) Boja	žuta		svijetlo žuta
(U) pH	7.0	pH j.	5.0 - 9.0
(U) Relativna volumna masa	1.018	kg/L	1.002 - 1.030
(U) Glukoza	negativna		norm.
(U) Bilirubin	negativan		0/neg
(U) Ketoni	negativni		0/neg
(U) Eritrociti/Hemoglobin	negativni		0/neg
(U) Proteini	negativni		0/neg
(U) Urobilinogen	norm. / ~3.2	µmol/L	norm;<17
(U) Nitriti	negativni		0/neg
(U) Leukocitna esteraza	negativna		0/neg

KLINIČKA BIOKEMIJA

	Rezultat	Jedinica	Ref.interval
(S) Glukoza	4.7	mmol/L	4.2 - 6.0
(S) Ureja	6.5	mmol/L	2.8 - 8.3
(S) Kreatinin	80	µmol/L	64 - 104
(S) Urati	422 H	µmol/L	182 - 403
(S) Bilirubin, ukupni	13	µmol/L	3 - 20
(S) ALT	34	U/L	12 - 48
(S) AST	19	U/L	11 - 38
(S) GGT	17	U/L	11 - 55
(S) Kalij	4.6	mmol/L	3.9 - 5.1
(S) Natrij	138	mmol/L	137 - 146
(S) Kloridi	101	mmol/L	97 - 108
(S) Kalcij, ukupni	2.34	mmol/L	2.14 - 2.53

Biokemija - lipidi

	Rezultat	Jedinica	Ref.interval
(S) Kolesterol	3.6	mmol/L	< 5.0
(S) HDL-kolesterol	1.2	mmol/L	> 1.0
(S) LDL-kolesterol	2.1	mmol/L	-za osobe s vrlo velikim rizikom <1.4 -velikim rizikom <1.8 -umjerenim rizikom <2.6 -malim rizikom <3.0
(S) Trigliceridi	0.6	mmol/L	< 1.7

Zdravka Doljanin
mag.med.biochem.

427051

Nalaz izdao/la:

Zdravka Doljanin, mag.med.biochem.

Voditelj laboratorija:

Zdravka Doljanin, mag.med.biochem.


INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST YELLOW FEVER
CERTIFICAT INTERNATIONAL DE VACCINATION OU DE REVACCINATION CONTRE LA FIEVRE JAUNE
MEĐUNARODNO UVJERENJE O VAKCINIRANJU ILI REVAKCINIRANJU ŽUTE GROZNICE

This is to certify that
 Je soussigné(e) certifie que
 Dolje potpisani potvrđuje da je

popisno ime: **VEDRAM** date of birth / né(e) le: **1996** sex / sexe: **M**
 rođeno(a) mjesto / lieu de naissance: **BILONIC**

whose signature follows
 dont la signature suit
 čiji potpis slijedi

has on the date indicated been vaccinated or revaccinated against yellow fever
 a été vacciné(e) ou revacciné(e) contre la fièvre jaune à la date indiquée.
 bio(la) vakciniran(a) ili revakciniran(a) protiv žute groznice označenog datuma

Date Datum	Signature and professional status of vaccinator Signature et qualité professionnelle du vacinateur Potpis i stručno zvanje osobe koja vrši vakciniranje	Origin and batch no. of vaccine Origine du vaccin employé et numéro du lot Porijeklo vakcine i broj serije	Official stamp of vaccinating centre Cachet officiel du centre de vaccination Službeni pečat centra za vakciniranje
17.08.2016	<i>Dr. sc. Tomislav Petrić, dr. med. specijalist infektivne bolesti Brijuni, ul. S. J. 188926</i>	STANARIL L5199-1	
2			
3			
4			

This certificate is valid only if the vaccine used has been approved by the World Health Organization and if the vaccinating centre has been designated by the health administration for the territory in which that centre is situated.
 The validity of this certificate shall extend for a period of ten years, beginning ten days after that date of vaccination or, in the event of a revaccination within such period of ten years, from the date of that revaccination.
 Any amendment of this certificate, or erasure, or failure to complete any part of it, may render it invalid.
 Ce certificat n'est valable que si le vaccin employé a été approuvé par l'Organisation mondiale de la Santé et si le centre de vaccination a été habilité par l'administration sanitaire du territoire dans lequel ce centre est situé.
 La validité de ce certificat couvre une période de dix ans commençant dix jours après la date de la vaccination ou, dans le cas d'une revaccination au cours de cette période de dix ans, le jour de cette revaccination.
 Toute correction ou rature sur le certificat ou l'omission d'une quelconque des mentions qu'il comporte peut affecter sa validité.
 Ovo uvjerenje važi samo ako je upotrijebljenu vakcinu odobrila Svjetska zdravstvena organizacija i ako je centar za vakciniranje dobio ovlaštenje od zdravstvene uprave područja na kojem se centar nalazi.
 Važnost ovog uvjerenja obuhvaća razdoblje od deset godina, koje počinje deset dana poslije datuma vakciniranja ili u slučaju revakciniranja u toku ovog razdoblja od 10 godina, danom ovog vakciniranja.
 Svako ispravljanje ili brisanje na uvjerenju ili izostavljanje bilo kog podatka koji ono sadrži može da utječe na njegovu valjanost.



Ustanova za zdravstvenu skrb dr. Milena Matulić za djelatnost medicine rada

Ul. Domovinskog rata 45, 21000 Split; OIB: 32050939559

Tel/fax: 021 266 006; e-mail: ustanova.matulic@gmail.com

www.zdravstvena-skrb-matulic.hr

Bilonić Vedran born 08.09.1996.

According to the available medical documentation Hepatitis B vaccinations were done :

12.09.2008.

23.10.2008

19.03.2009.

dr. MILENA MATULIĆ
USTANOVA ZA ZDRAVSTVENU SKRB
dr. MILENA MATULIĆ
ZA DJELATNOST MEDICINE RADA
Ulica Domovinskog rata 45. 21000 Split

Predškolska dob	
PRIMARNO CIEPLJENJE	BCG
	Di-Te-Per 03.02.97, 19.03.97, 26.05.97,
	POLIO -K -K -K
	MORBILLI } RUBEOLA } 28.10.97, PAROTITIS }
	BCG
REVAKCINACIJA	Di-Te-Per 18.09.98, 20.11.00,
	POLIO -K -K

Školska dob	
PRIMARNO CIEPLJENJE	BCG 18.12.2003 PPD 04.12.06 + 7m
	Ana-Di-Te 31.10.03 21.10.10.
	POLIO 31.10.03 19. 21.10.10.
REVAKCINACIJA	MORBILLI 12.06.2003. RUBEOLA PAROTITIS
	HEPATITIS B 12.09.2008. 23.10.2008 19.05.2009

Predškolska dob	
PRIMARNO CIEPLJENJE	BCG
	Di-Te-Per
	POLIO
	MORBILLI RUBEOLA PAROTITIS
	BCG
REVAKCINACIJA	Di-Te-Per
	POLIO

Školska dob	
PRIMARNO CIEPLJENJE	BCG
	Ana-Di-Te
	POLIO 17.11.2014
REVAKCINACIJA	MORBILLI RUBEOLA PAROTITIS
	HEPATITIS B

Date 04. / 04. / 2022

Con la presente certifico che il Sig./Signora
I hereby certify that Mr./Ms

Vedran Bilonić

Matr./ID n° 08 / 09 / 1996

Person n°

Ha ricevuto il vaccino COVID-19 in data: ____/____/____ lotto n° ____ con scadenza

____/____/____
He/she received COVID-19 vaccination 28 / 10 / 2021 lot n° ____ expire date
12 06 03'

Ha/she received VA-RIBAVAC I.A. vaccination ____/____/____ lot n° ____ expire date

____/____/____

Ha già contratto in passato le seguenti malattie esantematiche:

He/she already contracted in the past the following diseases:

- Misurele Maszila
- Parotita Parotita
- Scarlatina Scarlatina
- Varicella Varicella

- 18.06.2000

Nome e Cognome del medico dichiarante:

Name and Family name of declaring doctor:

Numero di licenza del medico dichiarante:

Doctor's license number:

SPECIJALISTIČKA ORDINACIJA
OBITELJSKE MEDICINE
Dr. med. ANKA KOŠTIĆ MEŠIN
specijalista obiteljske medicine
SPLIT, MIŠINA 28

Dr. med. ANKA KOŠTIĆ MEŠIN
specijalista obiteljske medicine
* 113166

Titolo e Firma/Stamp and Signature

Vaccination Certificate Potvrda o cijepljenju



Surname(s) and forename(s)
Prezime (prezimana) i ime (imena)
BILONIĆ VEDRAN

Date of birth
Datum rođenja
08.09.1996.

Unique certificate identifier
Jedinstveni identifikator potvrde
01:HR:MH1A4JSPVYL5#P

Potvrda je valjana samo uz predočenje osobnog identifikacijskog dokumenta.

The certificate is only valid in combination with a personal identification document.

COVID-19 Disease or agent targeted: COVID-19 (SARS-CoV-2 or one of its variants)
Bolest ili agens na koji se cilja: COVID-19 (SARS-CoV-2 ili jedna od njegovih varijanti)

COVID-19 vaccine or prophylaxis
Cjepivo ili zaštita protiv COVID-19

COVID-19 vaccine product name
Naziv cjepiva protiv COVID-19

COVID-19 vaccine marketing authorization
holder or manufacturer
Nositelj odobrenja za stavljanje u promet cjepiva
Biontech Manufacturing GmbH

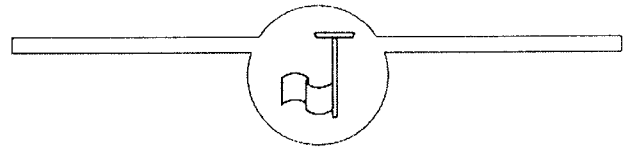
Number in a series of doses as well as the overall
number of doses in the series
Broj doza u odnosu na potreban broj i ukupan
broj doza u odnosu na potreban broj

Date of vaccination, indicating the date of the
latest dose received
Datum cijepljenja, uz naznaku datuma posljednje
primljene doze

Member State in which the vaccine was
administered
Država članica ili treća zemlja u kojoj je cjepivo
primljeno

Certificate issuer
Izdavatelj potvrde
Ministry of Health

EU Digital COVID Certificate EU digitalna COVID potvrda

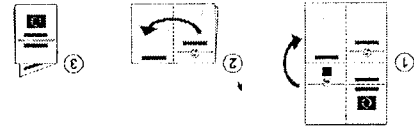


This certificate is not a travel document. The scientific evidence on COVID-19 vaccination, testing and recovery continues to evolve, also in view of new variants of concern of the virus. Before traveling, please check the applicable public health measures and related restrictions applied at the point of destination.

Relevant information can be found here: <https://european.eu/en/>

Ova potvrda nije putna isprava. Znanstveni dokazi o cijepljenju protiv bolesti COVID-19, testiranju i oporavku razvijaju se u skladu s novim saznanjima i novim varijantama virusa. Prije putovanja, provjerite važeće javnozdravstvene mjere i povezana ograničenja koja se primjenjuju u zemlji odredišta.

Relevantne informacije možete pronaći ovdje: <https://ireopen.europa.eu/hr/>



Lozinka za mobilnu aplikaciju: YLK8TC

Specijalna bolnica za opću kirurgiju, internu medicinu, radiologiju, ginekologiju, neurologiju, psihijatriju, oftalmologiju, fizikalnu medicinu i rehabilitaciju, laboratorijsku dijagnostiku, citologiju, otorinolaringologiju, urologiju, dermatologiju i venerologiju, ortopediju, medicinu rada i anesteziologiju, reanimatologiju i intenzivnu medicinu AGRAM OIB 89718348767

Specijalna bolnica AGRAM

Pacijent: **VEDRAN BILONIĆ**
Adresa: **PUJANKE 34, 21000 SPLIT**
Spol: **M**
Dat. rođenja: **8.9.1996.**

Broj protokola: **202200054615**
Nalaz: **9990095/11042022**
Datum pregleda: **11.4.2022.**
Telefon: **095 516 6428**

Sumacijska snimka torakalnih organa (PA i L profil)

Nalaz RTG snimke srca i pluća:

Na prikazanom plućnom parenhimu ne vidi se znakova infiltrativnih promjena.
Hilovaskularni crtež urednog raspjeta.
Srčana sjena u fiziološkim omjerima.
Kupole ošita primjereno svedene, f.c. sinusi su slobodni.

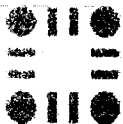
Dg.

NATAŠA MALEŠ RAŠKOVIĆ, dr.med.
spec. radiologije
Broj licence: 34276

CHEST X RAY

WNL

USTANOVA ZA ZDRAVSTVENU SKRB
dr. MILENA MATULIĆ
ZA DJELATNOST MEDICINE RADA
Ulica Domovinskog rata 45, 21000 Split



Klinički
bolnički
centar
Split

Klinika za plućne bolesti
Predstojnik: doc.dr.sc. SUZANA MLADINOV dr.med.

Poliklinika i dnevna bolnica
Pulmološka opća ambulanta 1

Adresa: Spinčićeva 1, SPLIT
Telefon: 021 556 062;

KLINIČKI BOLNIČKI CENTAR SPLIT
KLINIKA ZA PLUĆNE BOLESTI
Opća dječja ambulanta

SPECIJALISTIČKI NALAZ

Broj protokola: 20220398454

Prezime i ime: **BILONIĆ VEDRAN**

Adresa: PUJANKE 34, 21000 SPLIT

Spol: Muški

MBOO: 155288674

Datum rođenja: 08.09.1996.

Početak pregleda: 14.04.2022 09:16

Dijagnoze

Z03 Medicinsko promatranje i praćenje (opservacija i evaluacija) zbog sumnje na bolest i bolesna stanja

Zaključak:

Mantoux tuberculin skin test (PPD) - 5 x 7 mm

Datum: 14.04.2022 .

Liječnik: **TONI BOŽINOVIĆ**, dr.med.

SPECIJALIST PULMOLOG

7768685

NAPOMENA: Kod svakog novog pregleda molimo Vas ponosite ovaj nalaz.

Umjesto propisanog lijeka izabrani doktor primarne zdravstvene zaštite može propisati i drugi lijek istog razreda učinkovitosti u odgovarajućim jednakim dozama.

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specijalist pulmolog
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TUBERCULIN SKIN TEST

WINL

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