



THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

MAR

FOR DIVISION USE ONLY

Board of Marine Pilots

PO Box 110806, Juneau AK 99811

Phone: (907) 465-2550

Email: BoardOfMarinePilots@Alaska.Gov

Website: ProfessionalLicense.Alaska.Gov/BoardOfMarinePilots

Certificate of Medical Examination

The State of Alaska requires an examination to determine that all State of Alaska licensed marine pilots, deputy marine pilots, and authorized pilot trainees are of sound health, with no physical or mental limitations that would hinder or prevent performance of duties.

Applicant: Please complete the identifying information below and forward a copy of this form to the examining licensed physician (MD or DO).

Form with fields for Applicant Name, License Number, Mailing Address (P.O. Box or Street, City, State, Zip), Place of Birth, and Date of Birth.

1. Are you currently taking any medications (prescription or over-the-counter) or do you have an active prescription for an existing condition? If yes, identify all medications in #4 below and explain fully to the examining physician. [ ] Yes [ ] No

2. Do you have any medical condition, physical impairment, or mental condition which may interfere with the performance of your duties as per 12 AAC 56.025(a)(10) and 12 AAC 56.080(b)(2)? If yes, identify in #4 below and explain fully to the examining physician. [ ] Yes [ ] No

3. Are you currently under the care of any health care professionals other than the examining physician? If yes, identify all health care professionals and the conditions for which you are currently under the care of (not including the examining physician) in #4 below and explain fully to the examining physician. [ ] Yes [ ] No

4. Use this space if you answered "yes" to any of the questions above. Attach a separate sheet if necessary. [Blank lines for response]

## Applicant Signature

I certify that all information given by me in connection with this examination is correct to the best of my knowledge and belief in accordance with 12 AAC 56.025(a)(10) and 12 AAC 56.080(b)(2).

**Applicant Printed Name:**

**Applicant Signature:**

**Date Signed:**

### → Examining Physician:

Please complete this bottom part for the applicant identified above. If you have any questions, contact the State of Alaska Marine Pilot Coordinator at (907) 465-2548.

<b>Physician Name:</b> (MD or DO)		<b>Phone Number:</b>	
<b>Mailing Address:</b>	P.O. Box or Street	City	State      Zip

**A. Height:** \_\_\_\_\_ Feet, \_\_\_\_\_ Inches      **Weight:** \_\_\_\_\_ Pounds

**B. Eyes, Distant Vision: (Snellen)**  
**Without Glasses:** Left \_\_\_\_\_ Right \_\_\_\_\_      **With Glasses (If worn):** Left \_\_\_\_\_ Right \_\_\_\_\_

**C. Eyes, Color Vision:**  
 Is color vision normal when Ishihara or other color plate test is used?       Yes       No  
 If not, not, can applicant pass lantern, yarn or other comparable test?       Yes       No

**D. Ears (Consider denominators indicated here as normal. Record as numerators the greatest distance heard):**  
**Ordinary conversation:** Left Ear \_\_\_\_\_ /20 Feet; Right Ear \_\_\_\_\_ /20 Feet

**E. Drug Screening Urinalysis?** If "yes," the lab must mail results directly to the Marine Pilot Coordinator at the address on page 1.       Yes       No

**F. Other Findings:** In items (1) through (13), describe anomalies (including diseases, scars and brief history, if pertinent). Indicate if normal or if additional follow-up is recommended.

(1) **Eyes, ears, nose and throat (Including tooth & oral hygiene):** \_\_\_\_\_  
 \_\_\_\_\_

(2) **Head and back (including face, hair and scalp):** \_\_\_\_\_  
 \_\_\_\_\_

(3) **Speech (note any malfunction):** \_\_\_\_\_  
 \_\_\_\_\_

(4) **Skin and lymph nodes: (including thyroid gland):** \_\_\_\_\_  
 \_\_\_\_\_

(5) Abdomen: \_\_\_\_\_  
\_\_\_\_\_

(6) Peripheral blood vessels: \_\_\_\_\_  
\_\_\_\_\_

(7) Extremities: \_\_\_\_\_  
\_\_\_\_\_

(8) Urinalysis (if indicated): Sp. Gr. \_\_\_\_\_ Sugar: . \_\_\_\_\_ Blood: \_\_\_\_\_

Albumen: \_\_\_\_\_ Casts: \_\_\_\_\_ Pus: \_\_\_\_\_

(9) Respiratory tract (x-ray if indicated): \_\_\_\_\_  
\_\_\_\_\_

(10) Heart pulse (size, rate, rhythm, function): \_\_\_\_\_  
\_\_\_\_\_

(11) Back: \_\_\_\_\_  
\_\_\_\_\_

(12) Neurological & mental health: \_\_\_\_\_  
\_\_\_\_\_

(13) Medications review: \_\_\_\_\_  
\_\_\_\_\_

**G. Conclusions & Recommended Follow-Up** (check one of the following):

- I find no disqualifying factors at this time that would prevent this person from performing the duties of a marine pilot.
- I recommend follow-up as noted below.
- Summarize any medical findings which, in your opinion would materially limit this person's performance of duties or that you recommend for follow-up (if none, so state). Please note any issues with eyesight, hearing, blood pressure, physical agility, and cognitive capabilities as per 12 AAC 56.025(a)(10) and 12 AAC 56.080(b)(2):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Physician Signature

### Acknowledgement of Pilot Duties by Examining Physician:

- Pilot Responsibilities:** Marine pilots ensure the safe navigation of ships, directing movements based upon their unique knowledge of local weather, tides, current, hydrography and vessel handling characteristics. In addition to coping with the physical challenges of being at sea, the marine pilot must sift various and often simultaneous inputs from the bridge crew, radio traffic, complex navigation instruments, and their own senses to judiciously and timely arrive at a proper course of action. The pilot must communicate orders and coordinate with various bridge crew and other vessel traffic to ensure the safety of the vessel, the crew and cargo and the marine environment.
- Physical and Mental Abilities:** A marine pilot must be able to perform assigned shipboard functions and meet the demands that would reasonably arise during emergency response at any time of day or night, frequently during adverse weather and coping with the motion of the vessel while continuing in their duties; including (but not limited to) being capable of safely transferring between vessels at sea, climb a rope ladder and have the cognitive ability to process multiple inputs of information and make decisions without delay.
- Fitness-For-Duty:** A marine pilot must not have any medical or physical condition which will prohibit, obstruct, or negatively affect the full performance of their duty and be free from any medical conditions that pose a risk of sudden incapacitation which would affect transferring to and from and operating or working on vessels.
- Physician Acknowledgement:** I have read the above information and understand the duties and responsibilities of a State of Alaska marine pilot and have taken them into consideration during my evaluation of the above applicant.

Examining Physician  
Printed Name:

Examining Physician  
Signature:

Date Signed:



THE STATE  
of **ALASKA**  
*Department of Commerce, Community, and Economic Development*  
*Division of Corporations, Business and Professional Licensing*

FOR DIVISION USE ONLY

State of Alaska  
Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing  
PO Box 110806, Juneau, AK 99811  
Phone: (907) 465-2550

## Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: \_\_\_\_\_

Program Type: \_\_\_\_\_ License Number (if applicable): \_\_\_\_\_

I wish to make payment by credit card for the following (check all that apply):

**AMOUNT**

Application Fee: \_\_\_\_\_

License or Renewal Fee: \_\_\_\_\_

Other (name change, wall certificate, fine, duplicate license, exam, etc.):

1. \_\_\_\_\_

2. \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

Name (as shown on credit card): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email (optional): \_\_\_\_\_

Signature of Credit Card Holder: \_\_\_\_\_

08-4438

Rev 12/26/18

Credit Card Payment Form (all major cards accepted)

<b>CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!</b>	
<p>1. Account Number: _____</p> <p>2. Expiration Date: _____</p> <p>3. Billing ZIP Code: _____</p> <p>4. Security Code: _____</p>	<p>All four fields <b>MUST</b> be completed!</p> <p>This section will be destroyed after the payment is processed.</p>