ANKER
CREW INSURANCE

**Anker Alarm Service**
T:+31 50 520 99 04
E:assistance@anker.nl

# Authorization for medical attention/examination

Vessel:_____ Master:_____ Date:_____
Shipowner:_____ Agent:_____ Port:_____

Crew Member - Full Name:_____
Date of Birth:_____ Address:_____ Rank:_____
Nationality:_____ Passport:_____ ID No.:_____

To:_____Address:_____
Physician/Facility _____ _____
City/State Country

This crew member requests medical attention for the reasons indicated. Kindly furnish the necessary medical care, determine and state below whether he is fit/unfit for duty and indicate a specific medical diagnosis and additional medical treatment, if required.

_____ _____
Signature of Master Signature of Crew Member

**Cause of complaint**

☐ Accident Date:_____
☐ Illness

In case of an accident, please add a copy of the accident report

**Medical report:** (To be completed by examining physician)
Date/Time Examined:_____ **Recommendation:** Fit □ Unfit □ For Sea Duty

Prognosis:_____

If Unfit: Rest Aboard Vessel Y □ N □ May Travel Y □ N □
Hospitalization Required Y □ N □ By Air Y □ N □

_____ _____ _____ _____
Clinic Name Address City/State Country

_____
Telephone No.

_____ _____
Facsimile No. Signature of Physician

**If referral to a US based specialist or hospitalization is required, please call or fax Global Excel for approval and coordination. Unauthorized treatment will not be reimbursed. Please submit bills to Global Excel for payment:**

**Global Excel**
P.O BOX 10
BEEBE PLAIN, Vermont 05823
United States
T. + 1 866 566 3830
F. + 1 819 566 2852
E. notifications@globalexcel.com

GlobalExcel

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# MEDICAL CONSENT

**Subject** :

**Date** :

**Name of patient** :
**Date of birth** :

**Address** :
**Town, zip code** :
**Country** :
**Nationality** :

I, .....,

hereby authorize any hospital, physician or other person who has medically examined me, to furnish Anker Alarm Service any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment that were rendered to me. A Photostat/Faxed copy of this authorization shall be considered as effective and valid as the original. I understand that this authorization will allow Anker Alarm Service to use the information obtained to investigate and adjudicate my claims.

…….

(patient signature)

……

(witness signature)

……

(date signed by the above & location)