



# FSM Fisheries and Maritime Institute



College of Micronesia-FSM  
P.O. BOX 1056, Colonial, Yap  
Federated States of Micronesia 96943

Phone: (691)350-5244

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Office of the Registrar

## APPLICATION FOR ENROLMENT

Name		Date of Birth	Place of Birth	Nationality
Last	First	M/D/Y		
Height	Weight	Sex	Complexion	Course Applying for
		Male/Female		
Permanent Address			Social Security Number	
			FSM:	
			U.S.:	
Telephone Number:		Home:	Work:	
<b>Educational Background</b>				
School	Location		Year Attended	Certificate
<b>Work Experience:</b> <input type="checkbox"/> Fishing <input type="checkbox"/> Merchant Marine Service <input type="checkbox"/> Others _____				
Vessel/Company	Trade	Period of Employment	Position	Remarks
<b>Training Undertaken</b>				
Course Name	Dates of Attendance		Location	Certificate

**Reference:** Please provide the names and complete mailing and e-mail addresses, and phone and fax numbers of three persons who are not related to you but who may have sufficient knowledge of your behavior, background, education and work experience and may be used to provide information which could support your application.

**Sponsoring Agency:** Please provide the name and complete mailing and e-mail addresses, fax and phone number of the agency which will cover the costs of your education and training while at FSM Fisheries and Maritime Institute, or enrolled in one or more of its programs.

**Medical History:** The Seafarer's Medical Fitness form shall form a part of this Application. Without the Medical form, this Application will not be considered or processed.

**Police Clearance:** Please provide along with this application form a statement from the Police Department within your State or jurisdiction stating that you are clear from any criminal act or violation.

Write a short essay answering the question: Why do you want to attend FSM-FMI?

**Additional Information:** Please provide additional information that may be used to support your application.



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## TRANSCRIPT REQUEST FORM

**NOTE TO APPLICANT:** Complete this form and send it directly to the last school you attended. The school then shall send an official copy of your school transcript to FSM-FMI Registrar's Office.

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Date: \_\_\_\_\_

To: \_\_\_\_\_

Name of School last attended

\_\_\_\_\_  
School Address

\_\_\_\_\_  
State/Republic

\_\_\_\_\_  
Zip Code

Dear Sir:

I have applied for admission to the FSM-Fisheries and Maritime Institute and am required to furnish a transcript of previous education. Would you please forward a copy of my transcript to the following address:

FSM-Fisheries and Maritime Institute  
P.O. BOX 1059  
Yap, FM 96943

My name is \_\_\_\_\_  
Last First Middle Initial

My birthday is \_\_\_\_\_  
Month Day Year Date last attended your school

\_\_\_\_\_  
Signature

**FSM-FISHERIES AND MARITIME INSTITUTE  
College of Micronesia-FSM  
PO BOX 1056  
Colonia Yap, FM 96943**

**CANDIDATE CHECKLIST**

- 1. COPY OF BIRTH CERTIFICATE OR PASSPORT**
- 2. OFFICIAL COPY OF TRANSCRIPT**
- 3. POLICE CLEARANCE**
- 4. MEDICAL CERTIFICATE**
- 5. APPLICATION FOR ADMISSION FORM**

# SEAFARERS MEDICAL FITNESS CERTIFICATE

To conform to the 1995 Amendments to the STCW Convention 1978 & ISM Code

## To be completed by applicant

Surname: \_\_\_\_\_ First name/s: \_\_\_\_\_ Sex. M/F

Date of birth (mm/dd/yy): \_\_\_\_\_ Rank/Grading: \_\_\_\_\_

Home address: \_\_\_\_\_ (street/town/country)

Present Occupation: \_\_\_\_\_

Company which nominated: \_\_\_\_\_

1. Family history yes no
- a) Has anyone in your close family or household been treated for tuberculosis (TB) in the past ten years?
- b) Do you have a family history of heart disease, arthritis, rheumatism or diabetes?
- c) Has anyone in your family ever been treated for mental illness or 'nervous' conditions?

For physician's use only: Please provide further information if the answer to any of the above questions is 'yes'.

2. Personal history:

- Have you ever suffered from: yes no
- a) tuberculosis, spitting of blood or severe chest infection?
- b) conditions of the heart or lungs, including breathlessness, palpitation and high blood pressure?
- c) infection of the bladder, kidneys or urinary tract, including sexually transmitted infection?
- d) any condition of the stomach, liver or bowels, including hepatitis or stomach ulcer?
- e) convulsions, fits, epilepsy or severe migraine headaches?
- f) skin complaints, including skin cancers, which have required medical treatment?
- g) malaria or leprosy – still suffer repetitive effects from it? – still taking medication?
- h) diabetes, rheumatism, arthritis, hernia, stroke or cancer?
- i) any major accidents or recent (in past ten years) surgical treatment?

For physician's use only: please provide further information in the answer to any of the above questions is "yes".

3. General

- a) Do you wear glasses or corrective (contact) lenses?
- b) If yes, do you wear glasses for: (circle one) ..... reading ..... all the time?
- c) When did you last have a chest X-ray (year)?.....
- d) When did you last consult your doctor for an illness (month and year)?.....

**Confidential – Examining Medical Officer’s Report**

1. Physical examination:

Candidate’s general appearance: .....  
(comment on visible signs of ill health and/or disability)

Height ..... Weight .....

Blood pressure ..... Pulse rate .....

Urinalysis .....

Is there any evidence of heart and/or lung disease?

Is a chest X-ray required? (consider history as well as examination results)

Is there any evidence of:

Past or recent ear, nose and/or throat infections?

Defect in sight or hearing (surgery tests essential)?

Enlarged glands, varicose veins, skin lesions?

Conditions of the uro-genital organs and tract?

Disease of the brain, spinal cord or nervous system?

Does the applicant take any regular medication?

Name of medication and reason for taking? .....

Other comments .....

2. Psychological assessment

Does the applicant drink alcohol?

In your opinion, is the applicant a mild, moderate or heavy drinker?

Does the patient have a history of, or is he/she currently using drugs?

Is the applicant aware of the possible health risks associated with having

Unprotected sexual encounters whilst employed as a seafarer?

Is the applicant aware of the protective effects of condoms against possible health risks?

In your opinion, is the applicant a mature, responsible person who will

Manage employment as a seafarer?

Comments:

.....  
.....  
.....  
.....

**Medical Officer's Recommendations**

(The examining doctor is requested to inform the candidate whether acceptance, deferment, or rejection is recommended).

Fit for contract service for ..... years

Fit for permanent service .....

Deferred for .....months

Rejected .....

Results of chest X-ray .....

What further tests/investigations need to be undertaken for the candidate to be considered eligible?

.....

Other comments: .....

.....

.....

Signature, examining doctor: ..... Signature, applicant: .....

Print name: ..... Print name: .....

Date: ..... Date: .....

Employment:

Approved

Not approved

<p>Medical practitioner's name: .....</p> <p>Address: .....</p> <p>Provider/registration number: .....</p> <p>Telephone No.: ..... Fax No: ..... E-mail: .....</p>
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Note:

- (1) The Examining Physician should retain a copy of this certificate.
- (2) The Marine Department should retain a copy of this certificate.
- (3) It is the responsibility of the seafarer to have a current Medical Fitness Certificate.