Patriot Contract Services, LLC
American Ship Management, LLC

Author: Director of Labor Approved by: President Revision: 5 Valid from: 02/23/2021

HR-145_Crew Data Form

General Instructions: This form shall be completed by the crewmember prior to joining a vessel. Once completed, this form is to be faxed or emailed to the PCS Crewing Department by the dispatching union. The union is also to provide a copy of the completed form to the crewmember so they may submit it to the Captain (OIC while in ROS) when signing onto the vessel. Crewmembers should also retain copies for their records. This form is intended to be filled out electronically. A copy will be retained onboard ship for 1 year. A copy will be retained by the PCS Crewing Department for 5 years. Each section of this form must be fully completed. Incomplete forms or sections will be returned.

Full Last Name:	***Full First Name:***	***Full Middle Name****: (NMN if no middle name)*
Social Security Number:	***Merchant Mariner Reference Number:***	***MMD Exp. Date:***
Street Address*: (must accept overnight delivery- no PO box)*	***City and State:***	***Zip Code:***
Day time Telephone Number:	***Cell Phone / Pager Number:***	***Email:***
Birthplace City, State, Country:	***Birth Date:***	***Citizenship:***

Desired Airport:	***TWIC Expiration Date:***

Passport Number:	***Passport Issue Date:***	***Passport Expiration Date:***

Complexion:	***Eye Color:***	***Hair Color:***	***Weight:***	***Height:***	***Sex:***

Drivers License Number:	***State of Issuance***
Are you a veteran? What branch of service?	***Are you a maritime academy/school graduate? What school?***
__ *yes* __ *no*	__ *yes* __ *no*

Next of Kin Last Name:	***Next Of Kin First Name:***	***Relationship:***
Next of Kin Street Address: *(no PO box)*	***Next of Kin City, State and Zip Code:***	***Next of Kin Day Time Phone Number:***

401k Deduction: (IF APPLCIABLE BY CONTRACT)	***Overtime Conversion to Vacation: (IF APPLCIABLE BY CONTRACT)***
	☐ ***None*** ☐ ***Some (# of hours)*** ☐ ***All***

Printed copies are uncontrolled and must be identical to the electronic version.

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Section 1- DIRECT DEPOSIT

You must have an active checking or savings account for Direct deposit. If you choose Direct Deposit (electronic bank transfer) you must complete the following and include a copy of a voided check. Funds will not be available

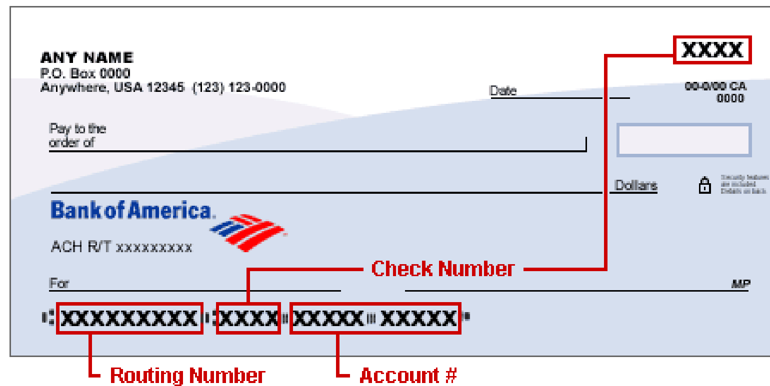
for transfer up to two (2) pay period.

Section 2 – MANUAL (LIVE) CHECK

~~If you did not elect Direct deposit and if not otherwise indicated below, checks will be sent to your home address.~~

SECTION 1

Name (Last):	***First :***	***Middle:***
Bank Name:	***Routing number (bank number):***	***Account #***



If you are unable to provide a copy of a voided check you must sign below verifying that the account information listed in section one (1) is accurate and that Patriot Contract Services, LLC will not be responsible for lost funds deposited incorrectly due to inaccurate information provided by you.
Crewmember Signature__________________________________ Date:_______________

SECTION 2

I WILL NOT BE ELECTING DIRECT DEPOSIT AND REQUEST MY PAYROLL CHECK IS SENT TO…
(if no option is selected your check will automatically be sent to your home address)

□ *MY HOME ADDRESS PROVIDED ON MY W-4 FORM*

□ *THE VESSEL I AM CURRENTLY ASSIGNED TO*

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Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the** name **on your social security card?** If not, to ensure **you** get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov.*
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing Jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up **a** home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ ______

Multiply the number of other dependents by $500 . . . . ▶ $ ______

Add the amounts above and enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . **4(b)** $

(c) **Extra withholding.** Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ **Employee's signature** (This form is not valid unless you sign it.) ▶ **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

NAME:
DATE

MSC COVID-19 Screening Questionnaire

(V20210416)

1. Are you currently feeling SICK YES NO

Have you had any of the following symptoms in the last 24 hours?

a. Fever	e. New Loss of smell or taste	YES	NO
b. Cough (not due to allergies)	f. Chills	YES	NO
c. Sore Throat	g. Muscle Pain (not related to physical activity)	YES	NO
d. Shortness of Breath	h. Headache **	YES	NO

If "YES", LEAVE/DO NOT ENTER WORKSPACE/VESSEL, CIVMAR inform Master, Uniformed inform chain-of-command, GS inform supervisor, CTR inform employer. Put a clean mask on when one is available, and contact/report to your medical provider. Follow CDC guidance (Footnote 1). ***Entry denied**

** If the **only symptom answered "Yes"** is headache, **refer to Medical or Master for temperature and interview.**

2. Have you **TRAVELED INTERNATIONALLY** in the last 14 days? YES NO

If "YES" DO NOT ENTER WORKSPACE/VESSEL – Entry denied

MSC Personnel: Complete 14 Days ROM, DO NOT ENTER for 14 days. CIVMAR inform Master, Uniformed inform chain-of-command, GS / CTR inform supervisor (Footnote 2). Follow CDC guidance (Footnote 3). ***Entry denied**

3. Have you **received an approved COVID-19 vaccination?** YES NO

a. **If YES**, did you complete the vaccination series? YES NO

b. **If YES**, was the series completed more than 2 weeks ago? YES NO

c. **If YES**, can person produce written/electronic documented proof of vaccination? YES NO

Note 1: If yes to all three questions, allow entry and no further questions required.

Note 2: If no to any question, proceed to question 4

4. Have you **been TESTED FOR COVID-19** in the last 14 days? YES NO

If "YES" Ask the following: What were the results of that test? Positive/Negative/Still Awaiting Results

If "Positive" or "Still Awaiting Results" – LEAVE/DO NOT ENTER WORKSPACE/VESSEL.

CIVMAR inform Master, Uniformed inform chain-of-command, GS inform supervisor, CTR inform employer (Footnote 2). **Entry denied.**

Note 1: Refusal to provide an answer to this question shall be considered a "**positive**" result and treated accordingly.

Note 2: If person was tested as part of completing ROM-Sequester, or for other reasons unrelated to possible contact with COVID-19, and person is still awaiting test results, they may be permitted entry at the discretion of the Master/Supervisor.

5. Have you **TRAVELED OUTSIDE THE LOCAL AREA** in the last 14 days? YES NO

If "YES", DO NOT ENTER WORKSPACE/VESSEL, Put a clean mask on when one is available, and contact/report to Medical/Master for secondary screening. Follow CDC guidance (Footnote 1). **Entry denied.**

Note 1: See attached matrix to assist with travel risk assessment in secondary screening.

Note 2: If in CONUS, review assessment of state/county specific risk as part of secondary screening (Footnote 4/CAC required).

6. Have you had **CLOSE PERSONAL CONTACT,** with anyone who has been diagnosed with COVID-19 or exhibiting symptoms (fever, cough, sore throat, etc.) in the last 14 days? YES NO

If "YES", LEAVE/DO NOT ENTER WORKSPACE/VESSEL, CIVMAR inform Master, Uniformed inform chain-of-command, GS inform supervisor, CTR inform employer. Put a clean mask on when one is available, and contact/report to your medical provider. Follow CDC guidance (Footnote 1). ***Entry denied**

7. Once instructed by higher authority, **CONDUCT TEMPERATURE CHECKS:**

a. If temperature is less than 100°F {37.8°C), allow access. Screening is complete.

b. If temperature is equal to or higher than l00°F (37.8°C), LEAVE/DO NOT ENTER WORKSPACE/VESSEL, CIVMAR inform Master, Uniformed inform chain-of-command, GS inform supervisor, CTR inform employer, put a clean mask on when one is available, and contact/report to your medical provider (call ahead to inform them of your pending arrival). Follow CDC Guidance. (Footnote 1) **Entry denied**

DENY ENTRY TO ANYONE WHO FAILS TO COOPERATE OR PROVIDE ANSWERS TO THE ABOVE QUESTIONS

Footnote 1 https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.htm

Footnote 2 OSD Memo Force Health Protection Guidance Supplement 8 (13Apr20)

Footnote 3 https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-trave1-precautions.htm

Footnote 4 https://www.mnp.navy.mil/group/don-covid-19-travel-tracker

PATRIOT CONTRACT SERVICES, LLC

SEAMAN'S DECLARATION OF HEALTH AND MEDICAL AUTHORIZATION

(Pre-sign on, after selection of the job from the Union Hall)

I, ______________________________, present myself for employment aboard the vessel,
(print your name)

______________________________ and state that I am physically, mentally and professionally fit to
(name of vessel)

perform my assigned duties as ______________________________
(state your rating)

PLEASE ANSWER THE FOLLOWING:

NOTE: FAILURE TO ANSWER ALL QUESTIONS COMPLETELY AND TRUTHFULLY, OR WILLFULLY CONCEALING ANY PHYSICAL OR MENTAL CONDITION WHICH AFFECTS YOUR ABILITY TO PERFORM YOUR DUTIES, MAY RESULT IN YOUR MAINTENANCE AND CURE BENEFITS BEING DENIED AND/OR TERMINATION OF EMPLOYMENT.

Have you received medical treatment and/or had surgery within the last two years? ☐ **Yes** ☐ **No**

If yes, please provide the following information.

1. **Nature of illness or injury:** ______________________________
2. **Name and address of doctor, hospital and medical facility:** ______________________________
3. **Dates of treatment:** ______________________________
4. **Date released from treatment:** ______________________________

Check below if you now have, or ever have had, the following: ***(Explain any "YES" answers on the back of this form.)***

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Alcoholism/Drug Dep	☐	☐	Are you now pregnant?	☐	☐	Arthritis	☐	☐
Asthma	☐	☐	Back ache/back injury	☐	☐	Blood in urine or stool	☐	☐
Broken or Fractured bones	☐	☐	Cancer	☐	☐	Coronary illness	☐	☐
Chronic or Migraine headache	☐	☐	Diabetes	☐	☐	Dizziness or fainting	☐	☐
Epilepsy	☐	☐	Head injury	☐	☐	Heart trouble	☐	☐
Hepatitis	☐	☐	Hernia	☐	☐	High blood pressure	☐	☐
Kidney disease	☐	☐	Liver Disease	☐	☐	Lung/Respiratory Illness	☐	☐
Malaria	☐	☐	Mental/nervous disorder	☐	☐	Neck ache/neck injury	☐	☐
Psychiatric treatment	☐	☐	Rheumatism	☐	☐	Stomach illness	☐	☐
Tuberculosis (PPD)	☐	☐	Ulcer	☐	☐	Venereal disease	☐	☐

PPD Test Date: **Results:**

Any other injury or illness not listed above: ______________________________

Are you presently taking any medications? ☐ **Yes** ☐ **No**

If yes, please identify the medications you are taking, with dosage and frequency:

____

Do you have sufficient medication to complete the voyage? ☐ **Yes** ☐ **No**

Do you have any allergies to food, medication, latex, etc? ☐ **Yes** ☐ **No**

If yes, identify all allergies: ______________________________

CERTIFICATION AND AUTHORIZATION

In the event I become ill or injured, this form will serve as a MEDICAL AUTHORIZATION for Patriot Contract Services, LLC, to obtain past, present, and future medical records concerning my treatment, from any physician or medical facility.
I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT AND THAT MY SIGNATURE HERETO RELEASES THE MEDICAL INFORMATION AS AUTHORIZED ABOVE.

Signature: ______________________________ **Date:** ______________

VESSEL OFFICER REVIEW

CG 4610A – Medical Certificate STCW Expiration Date: ____/____/____ National Expiration Date: ____/____/____

International Certificate of Vaccination received by Vessel Officer Date:____/____/____

Other Documents Required:

Unlicensed	Date	Licensed	Date
Clinic card valid through	____/____/____	CG drug clearance (attach)	____/____/____
Date of last exam	____/____/____	Permanent(MARAD): Annual	____/____/____
CG drug clearance (attach)	____/____/____	MSC Physical	____/____/____
Attach Fit for Duty Slip	____/____/____	Attach Fit for Duty Slip	____/____/____
MSC Physical	____/____/____		

Signature reviewing vessel officer: ______________________________ **Date:** ______________

Distribution: Original to Claims; copy to be retained on board the vessel.

Approved By: CLM

EMPLOYEE DRUG / ALCOHOL CERTIFICATION AND CONSENT FORM

Applicant's Name: ____ ***SSN:*** _____ ___ _______

Vessel: ____ ***Rating:*** ______________

Pursuant to US Dept of Transportation Regulation (DOT) 49CFR40.25, paragraph "J", you must respond truthfully to the following questions. During the past 24 mos., with respect to DOT/USCG pre-employment drug or alcohol testing, have you:

	Yes	No
• Had alcohol tests with a result of 0.04 or higher concentration?	☐	☐
• Had verified positive drug tests?	☐	☐
• Refused to test or had verified adulterated or substituted drug test results?	☐	☐
• Violated any other DOT/USCG drug and alcohol testing regulation?	☐	☐

With respect to any violation of the DOT/USCG chemical testing regulations, please provide documentation of your completion of DOT "return-to-duty" requirements including follow-up tests. **(Please attach documentation)**

If you answered YES to any of the above questions, please provide our company with the following information:

Name of Substance Abuse Clinic/Professional: ______________________________________

Tel: ______________________________ ***E-mail:***______________________ ***Fax:*** ______________________

I have not been previously been employed in a positon requiring DOT/USCG chemical testing.
Yes☐ No☐ (if no, then answer next question)

The only DOT/USCG employer I have worked for in the previous 24 months is Patriot Contract Services.
Yes☐ (if yes, then sign and date below) No☐ (if no, then answer next question)

List only DOT/USCG employers you have worked for during the past 24 months. If you worked for other or multiple companies <u>and</u> for Patriot Contract Services, LLC during the past 24 months, then list only employers you worked for since you last worked for Patriot.

Previous DOT Employer: __________________ ***Vessel:*** __________ ***Contact Person:***_______________
Tel No.: _____________ ***Fax No.:*** _____________ ***Employed From:*** ____/____/____ ***To:*** ____/____/____

Previous DOT Employer: __________________ ***Vessel:*** __________ ***Contact Person:***_______________
Tel No.: _____________ ***Fax No.:*** _____________ ***Employed From:*** ____/____/____ ***To:*** ____/____/____

Previous DOT Employer: __________________ ***Vessel:*** __________ ***Contact Person:***_______________
Tel No.: _____________ ***Fax No.:*** _____________ ***Employed From:*** ____/____/____ ***To:*** ____/____/____

I hereby authorize previous employer(s) to release the information with regard to my chemical testing records to my prospective employer.

Seaman's Signature: ____ *Date:* __________________

TO BE COMPLETED ONLY BY PREVIOUS EMPLOYERS

	Yes	No
Had alcohol tests with a result of 0.04 or higher concentration?	☐	☐
Had verified positive drug tests?	☐	☐
Refused to test or had verified adulterated or substituted drug test results?	☐	☐
Violated any other DOT/USCG drug and alcohol testing regulation?	☐	☐

With respect to any violation of the DOT/USCG chemical testing regulations, please provide documentation of the applicant /employee's completion of DOT "return-to-duty" requirements, including follow-up tests.

Previous Employer: _______________________ Signature:_____________________ Date: ____/____/____

Please email the completed form to: Patriot Contract Service- Marine Personnel- crewing@asmhq.com

Patriot Contract Services, LLC

MEDICAL REQUEST FORM

All below listed sections must be completed and returned prior to physical approval. Anderson & Kelley (Patriot's third party medical provider) will contact you directly for scheduling.

Name (first, Middle, last):

Today's Date:

Social Security Number (last 4 only): ***-**-

Union: **Port of Dispatch:**

Vessel:

Expected Reporting Date (Month/Day):

City/State (Location physical will be scheduled)**:**

Contact Number (below):

- Primary: Type:
- Secondary: Type:

E-MAIL Address:

Last Tuberculosis Screening (below):

Date: Results: Never Screened/Unknown:

Frequency of MSC Physicals (COMSCINST 6000.1D):

Up to age 39:	Once
Ages 40-49:	Every 5 years
Age 50-59:	Every 2 years
Age 60 and over:	Annually

TUBERCULOSIS EXPOSURE RISK ASSESSMENT

FOR THE PATIENT *(Including those with previous positive tuberculin skin test)(Check the correct response)*

1. Since your last Tuberculosis Exposure Risk Assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ Yes ☐ No ☐ Don't Know

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; patients hospitalized with tuberculosis , prisoners, or homeless shelter populations? ☐ Yes ☐ No

3a. Check any countries where you have traveled or deployed to since your last Tuberculosis Exposure Risk Assessment.

☐ Bangladesh	☐ Ethiopia	☐ Pakistan	☐ UR Tanzania
☐ Brazil	☐ India	☐ Philippines	☐ Viet Nam
☐ Burma	☐ Indonesia	☐ Russian Federation	☐ Zimbabwe
☐ Cambodia	☐ Kenya	☐ South Africa	☐ None
☐ China	☐ Mozambique	☐ Thailand	
☐ DR Congo	☐ Nigeria	☐ Uganda	

If any of these listed countries are selected, answer question 3c.

☐ Other ______________________ If "other" is checked, write in the name of the country or countries.

3b. Have you recently traveled to Afghanistan for any reason other than as part of a deployment requiring completion of a Post Deployment Health Assessment (PDHA)? ☐ Yes ☐ No If Yes, go to 3c. Otherwise, go to 4a.

3c. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least 8 consecutive hours on a single day, or for a total of at least 15 hours per week of a multi-week stay. ☐ Yes ☐ No

4a. Have you recently had a chronic cough lasting more than 2 weeks? ☐ Yes ☐ No

4b. If you marked YES to chronic cough, did you have any of the following at the same time?

☐ Fever ☐ Cough up Blood ☐ Unexplained Weight Loss ☐ Night Sweats

If any are checked, see the medical officer for evaluation.

FOR THE SCREENER

1. Questions 1 through 4 reviewed, all responses are negative, no further action is required. ☐ Yes ☐ No
2. There is at least one positive answer, patient to continue to medical officer for assessment. ☐ Yes ☐ No

FOR THE PROVIDER

(Expand on above answers to document decision making in determining risk)

(Note: Prior treated TST reactors require clinical evaluation to rule out active TB, not a repeat TST).

1. Provider Comments

2. Tuberculosis risk assessment, based on above responses *(If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)* ☐ Minimal Risk ☐ Increased Risk

3. Recommend Latent Tuberculosis Infection (LTBI) Testing ☐ Yes ☐ No

PROVIDER'S NAME	PROVIDER'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

Last Name:
First Name: **Mid:**
SSN: **DOB:**
Gender:
Rating:

HOSPITAL OR MEDICAL FACILITY	STATUS
DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN
RELATIONSHIP TO SPONSOR	