



SEAFARER EMPLOYMENT APPLICATION

Post Applied For:

Trainee /OS	<input type="checkbox"/>	AB	<input type="checkbox"/>	Bosun	<input type="checkbox"/>
E/Cadet	<input type="checkbox"/>	D/Cadet	<input type="checkbox"/>	Medic	<input type="checkbox"/>
Electrician	<input type="checkbox"/>	Oiler	<input type="checkbox"/>	Cook	<input type="checkbox"/>
3/Engineer	<input type="checkbox"/>	2/Engineer	<input type="checkbox"/>	C/Engineer	<input type="checkbox"/>
2/Officer	<input type="checkbox"/>	C/Officer	<input type="checkbox"/>	Master	<input type="checkbox"/>

Attach 1 copy of
recent photograph
here
(Non-returnable)

*(Please tick✓)

A. PERSONAL PARTICULARS					
Name in Full (In block letters and as shown in I/C or Passport):			Correspondent Address:		
I/C No.:					
Travel Document:			Contact Details:		
Passport No _____			Tel No (Home) _____		
Date of Issue _____			Mobile No (HP) _____		
Date of Expiry _____			Email Address _____		
Date of Birth (DOB):		Place of Birth (POB):		Nationality:	
Religion:		Height:		Weight:	
EPF No:		SOCSSO No:		Tax No:	
Seaman Book No:		Seaman Card No:		Seaman Card Expiry Date:	
Eye Colour:		Hair Colour:		Preferred Airport:	
Coverall Size:		Safety Shoe Size:		Blood Type:	
Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Family Details					
Name of Spouse:		Age:			
Children Name:		Age:		Sex: DOB:	
Children Name:		Age:		Sex: DOB:	
Children Name:		Age:		Sex: DOB:	
Children Name:		Age:		Sex: DOB:	
Next of Kin Details					
Full Name:			Relationship:		
Address:			Telephone No:		



B. CERTIFICATE OF COMPETENCY							
Type of Certificate of Competency Held:							
Certificate No:		Issuing Authority:			Date of Issue:		
C. SEA EXPERIENCE (To be listed from top)							
Company	Vessel	Type	GRT	BHP	Rank	Sign-On	Sign-Off
D. MEDICAL HISTORY (It is utmost importance that all illness other than minor afflictions should be stated. The Company is entitled to refuse any claim for treatment, cost or any other insured benefits if a complete declaration of all previous illness has not been given)							
1) Have you ever signed off a ship due to medical reasons? If yes, please provide following details. Brief Description of illness / injury / accident: <input type="checkbox"/> Yes <input type="checkbox"/> No							
2) Have you undergone any medical operation in the past? If yes, please provide details. Brief Description of medical operation: <input type="checkbox"/> Yes <input type="checkbox"/> No							
3) Any health or physical disability problem? If yes, please provide details. Brief Description: <input type="checkbox"/> Yes <input type="checkbox"/> No							
4) Have you been seriously ill for the last 12 months? If yes, please provide details. Brief Description: <input type="checkbox"/> Yes <input type="checkbox"/> No							
5) Do you have the following illness: If yes, please tick the appropriate box. <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Asthma		<input type="checkbox"/> Heart					
<input type="checkbox"/> Blood Pressure		<input type="checkbox"/> Diabetic					
<input type="checkbox"/> Gout							

TANJUNG KAPAL SERVICES SDN BHD (316331-U)

No. 8-3, Jalan Puncak Setiawangsa 4, Taman Setiawangsa,

54200 Kuala Lumpur.

Tel: +60-3-4252 3888

Fax: +60-3-4252 3611

Email: kapal@tanjungoffshore.com.my

E. GENERAL		
Willing to accept lower rank?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ability to understand instructions in English (For Rating ONLY)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adequate understanding of written and spoken English (For Officers/Engineers)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Willing to work outside Malaysia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been denied a foreign visa? If yes, please state country and reason (if known)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been subject of a court enquiry or involved in maritime accident? If yes, please state details:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever work for Company or Vessel having ISM / ISO Certifications? If yes, please fill details below:		
Company	Vessel	Position
F. REFERENCES (Please give referees from 2 recent employers who we may contact for reference)		
Name of Company	Contact No	
Name of Company	Contact No	
G. BANK DETAILS		
Bank's Name	_____	
Account No	_____	
Account Holder Name	_____	
I/C No	_____	

I hereby declare that the above is true.

Date: _____

Signature: _____

H. OTHER CERTIFICATES HELD (To be filled by Crewing Executive / Overseas Manning Agencies)				
COURSES/CERTIFICATES	Verify	Number	Date of Issue	Date of Expiry
Basic Safety Training (BST)	<input type="checkbox"/>			
Proficiency in Survival Craft & Rescue Boat	<input type="checkbox"/>			
Advanced Fire Fighting	<input type="checkbox"/>			
Medical Care	<input type="checkbox"/>			
Medical 1 st Aid	<input type="checkbox"/>			
Radar Navigation & Radar Plotting	<input type="checkbox"/>			
ARPA Certificate	<input type="checkbox"/>			
GMDDS General Operator Certificate (GOC)	<input type="checkbox"/>			
Shipboard Management Course	<input type="checkbox"/>			
ISO / ISM Course	<input type="checkbox"/>			
Rating Watch Keeping Cert (Deck/Engine)	<input type="checkbox"/>			
Basic Rigging and Slings Course	<input type="checkbox"/>			
Ship Security Officer Certificate (SSO)	<input type="checkbox"/>			

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Email: kapal@tanjungoffshore.com.my**FOR OFFICE USE ONLY:**

I. INTERVIEWER'S ASSESSMENT		
Acceptance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name:
KIV	<input type="checkbox"/>	Date:
If NO, please give reason:		Signature:
J. MEDICAL FITNESS		
Medical Examination Certificate		Fit for Employment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Issue _____	Date of Expiry _____	
K. VESSEL ASSIGNMENT		
Name of Vessel:	Rank:	Effective Date:
Starting Salary:		
Comment (if any):		
Name:	Date:	Signature: