

LOGO

CIVIL AVIATION ADMINISTRATION / MEMBER STATE

**APPLICATION FORM FOR AN AVIATION MEDICAL CERTIFICATE**

Complete this page fully and in block capitals - Refer to instructions pages for details.

MEDICAL IN CONFIDENCE

(1) State of licence issue:		(2) Medical certificate applied for: class 1 <input type="checkbox"/> class 2 <input type="checkbox"/> LAPL <input type="checkbox"/> Others <input type="checkbox"/>			
(3) Surname:		(4) Previous surname(s):	(12) Application Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/>		
(5) Forenames:		(6) Date of birth(dd/mm/yyyy):	(7) Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		
(8) Place and country of birth:		(9) Nationality:	(13) Reference number:		
(10) Permanent address:  Country : Telephone No. : Mobile No. : e-mail :		(11) Postal address (if different)  Country : Telephone No. :			
				(14) Type of licence applied for:	
				(15) Occupation (principal) (16) Employer (17) Last medical examination Date: Place:	
(18) Aviation licence(s) held (type): Licence number: State of issue:		(19) Any Limitations on Licence/ Medical Certificate No <input type="checkbox"/> Yes <input type="checkbox"/> Details:			
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Country: Details:		(21) Flight time hours total:	(22) Flight time hours since last medical:		
(24) Any aviation accident or reported incident since last medical examination? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Place: Details:		(23) Aircraft class /type(s) presently flown:			
		(25) Type of flying intended: (26) Present flying activity: Single pilot <input type="checkbox"/> Multi pilot <input type="checkbox"/>			
(27) Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, amount		(28) Do you currently use any medication? No <input type="checkbox"/> Yes <input type="checkbox"/> State drug, dose, date started and why:			
(29) Do you smoke tobacco? <input type="checkbox"/> No, never <input type="checkbox"/> No, date stopped: <input type="checkbox"/> Yes, state type and amount:					

General and medical history: Do you have, or have you ever had, any of the following? (Please tick).

Note: if revalidating at the same venue as last examination, tick only boxes relating to any medical/surgical/ophthalmic or other events or changes since last examined. If 'no change, state this in 'Remarks..

	Yes	No	Yes	No	Yes	No	Family history of:	Yes	No		
101 Eye trouble/eye operation			112 Nose, throat or speech disorder			123 Malaria or other tropical disease			170 Heart disease		
102 Spectacles and/or contact lenses ever worn			113 Head injury or concussion			124 A positive HIV test			171 High blood pressure		
103 Spectacle/contact lens prescriptions change since last medical exam.			114 Frequent or severe headaches			125 Sexually transmitted disease			172 High cholesterol level		
104 Hay fever, other allergy			115 Dizziness or fainting spells			126 Admission to hospital			173 Epilepsy		
105 Asthma, lung disease			116 Unconsciousness for any reason			127 Any other illness or injury			174 Mental illness		
106 Heart or vascular trouble			117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			128 Visit to medical practitioner since last medical examination			175 Diabetes		
107 High or low blood pressure			118 Psychological/psychiatric trouble of any sort			129 Refusal of life insurance			176 Tuberculosis		
108 Kidney stone or blood in urine			119 Alcohol/drug/substance abuse			130 Refusal of flying licence			177 Allergy/asthma/eczema		
109 Diabetes, hormone disorder			120 Attempted suicide						178 Inherited disorders		
110 Stomach, liver or intestinal trouble			121 Motion sickness requiring medication			132 Medical rejection from or for military service			179 Glaucoma		
111 Deafness, ear disorder			122 Anaemia / Sickle cell trait/other blood disorders			133 Award of pension or compensation for injury or illness			<b>Females only:</b>		
									150 Gynaecological, menstrual problems		
									151 Are you pregnant?		

(30) **Remarks:** If previously reported and no change since, so state.

(31) **Declaration:** I hereby declare that I have carefully considered the statements made above and to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statements in connection with this application, or fail to release the supporting medical information, the Licensing Authority may refuse to grant me a medical certificate or may withdraw any medical certificate granted.

CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby authorise the release of all information contained in this report and any or all attachments to the Medical Assessor of the Licensing Authority and where necessary to the Medical Assessor of another EASA Member State, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the Licensing Authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times.

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Date Signature of applicant Signature of AME/GMP (witness)