**APPLICATION FORM FOR AVIATION MEDICAL CERTIFICATE**

Complete this page fully and in block capitals - Refer to instructions for details. MEDICAL IN CONFIDENCE

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

**General and medical history**: Do you have, or have you ever had, any of the following? YES or NO (or as indicated) must be ticked after each question. Elaborate YES answers in the remarks section.

Yes No Yes No Yes No Yes No

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 101 Eye trouble/eye operation |  |  | 113 Head injury or concussion |  |  | 125 Sexually transmitted disease |  |  | **Family history of:** |  |  |
| 102 Spectacles and/or contact lenses ever worn |  |  | 114 Frequent or severe headaches |  |  | 126 Admission to hospital |  |  | 170 Heart disease |  |  |
| 103 Spectacle/contact lens prescription change since last medical exam |  |  | 115 Dizziness or fainting spells |  |  | 127 Any other illness or injury |  |  | 171 High blood pressure |  |  |
| 104 Hay fever, other allergy |  |  | 116 Unconsciousness for any reason |  |  | 128 Visit to medical practitioner since last medical examination |  |  | 172 High cholesterol leve |  |  |
| 105 Asthma, lung disease |  |  | 117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc. |  |  | 129 Refusal of life insurance |  |  | 173 Epilepsy |  |  |
| 106 Heart or vascular trouble |  |  | 118 Psychological/psychiatric trouble of any sort. |  |  |  |  |  | 174 Mental illness |  |  |
| 107 High or low blood pressure |  |  | 119 alcohol/drug/substance abuse |  |  | 130 Refusal of flying licence |  |  | 175 Diabetes |  |  |
| 108 Kidney stone or blood in urin |  |  | 120 Attempted suicide |  |  | 132 Medical rejection from or for  military service |  |  | 176 Tuberculosis |  |  |
| 109 Diabetes, hormone disorder |  |  | 121 Motion sickness requiring  medication |  |  | 133 Award of pension or compensation for injury or illness |  |  | 177 Allergy/asthma/eczema |  |  |
| 110 Stomach, liver or intestinal trouble |  |  | 122 Anemia / Sickle cell trait/other  blood disorders |  |  | **Females only:** | | | 178 Inherited disorders |  |  |
| 111 Deafness, ear disorder |  |  | 123 Malaria or other tropical disease |  |  | 150 Gynaecological,  menstrual problems |  |  | 179 Glaucoma |  |  | |
| 112 Nose, throat or speech disorder |  |  | 124 A positive HIV test |  |  | 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 Authority may refuse to grant me a medical certificate or may withdraw any medical certificate granted, without prejudice to any other action applicable under national law. 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 Aeromedical Section and where necessary the Aeromedical Section of another JAA 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 Authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times.  --------------------------------------- ------------------------------------------------ --------------------------------------------  Date Signature of applicant Signature of AME (Witness) | | | | | | | | | | | |