**Application form for a medical certificate 1 / 2 / LAPL**

MEDICAL IN CONFIDENCE

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| Complete this page fully and in block capitals - Refer to instructions for completion. | | | | | | |
| (1) State of license issue: | | | (2) Medical certificate applied for:  □ CLASS 1 □CLASS 2 □ LAPL | | | |
| (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 license applied for: | | |
| (10) Permanent address:    Country:  Phone number: | (11) Postal address (if different):  Country:  Phone number: | | 15) Occupation (principal): | | | |
| Mobile No: | (16) Employer: | | | |
| E-mail: | (17) Last medical examination:  Date:  Place: | | | |
| (18) License(s) held type):  License number:  State of issue: | | | (19) Any limitations on license(s) / medical certificate held  □ NO □ YES  Details: | | | |
| (20) Have you ever had a medical certificate denied, suspended or revoked by any licensing authority ?  □ NO □ YES  Date: Country:  Details: | | | (21) Flight time total: | | | (22) Flight time since last medical: |
| (24) Any aircraft accident or reported incident since last medical examination?  □ No □ Yes  Date: Place:  Details | | | (23) Aircraft presently flown: | | | |
| (27) Do you drink alcohol?  □ No □ Yes , amount | | | (25) Type of flying intended: | | | |
| (28) Do you currently use any medication?  □ No □Yes  State drug, dose, date started and why: | | | (26) Present flying activity:  □ Single pilot □ Multi pilot | | | |
| (29) Do you smoke tobacco?  □ 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? (Please tick). If yes, give details in remarks section (30).

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|  | Yes | No |  | Yes | No |  | Yes | No | Family history of: | Yes | No |
| 101 Eye trouble/eye operation |  |  | 112 Nose, throat/speech disorder |  |  | 123 Malaria/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 Sleep disorder/apnea syndrome |  |  | 173 Epilepsy |  |  |
| 105 Asthma, lung disease |  |  | 116 Unconsciousness for any reason |  |  | 127 Musculoskeletal illness/ impairment |  |  | 174 Mental illness |  |  |
| 106 Heart or vascular trouble |  |  | 117 Neurological disorders, stroke, epilepsy, seizure, paralysis etc. |  |  | 128 Any other illness or injury |  |  | 175 Diabetes |  |  |
| 129 Admission to hospital |  |  |
| 107 High or low blood pressure |  |  | 118 Psychological/psychiatric trouble of any sort |  |  | 130 Visit to medical practitioner since last medical examination |  |  | 176Tuberculosis |  |  |
| 108 Kidneys stone or blood in urine |  |  | 119 Alcohol /drug substance abuse |  |  | 131 Refusal of life insurance |  |  | 177 Allergy/ asthma/ eczema |  |  |
| 109 Diabetes, hormone disorder |  |  | 120 Attempted suicide |  |  | 132 Refusal of flying license |  |  | 178 Inherited disorders |  |  |
| 110Stomach, liver/ intestinal trouble |  |  | 121 Motion sickness requiring medication |  |  | 133 Medical rejection from or for military Service |  |  | 179Glaucoma |  |  |
| 111Deafness, ear disorder |  |  | 122 Anemia / Sickle cell trait / other blood disorders |  |  | 134Award of pension or compensation for injury or illness |  |  | FEMALES ONLY | | |
| 150Gynaecological, menstrual problems |  |  |
| 151 Are you pregnant? |  |  |
| (30) Remarks: If previously reported and no change since, so state. | | | | | | | | | | | |

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| (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 without prejudice to any other action applicable under national law.  CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby authorize the release of all information contained in this report and any or all attachments to the AME and, where necessary, to the medical assessor of the licensing authority, recognizing 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. | | |
| Date | Signature of applicant | Signature of AME (medical assessor) |

**INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FORM FOR A MEDICAL CERTIFICATE**

This application form and all attached report forms will be transmitted to the licensing authority. Medical confidentiality shall be respected at all times.The applicant should personally complete, in full, all questions (sections) on the application form. Writing should be legible and in block capitals, using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any questions, a plain sheet of paper should be used, bearing the applicant’s name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the application form for a medical certificate.Failure to complete the application form in full, or to write legibly, may result in non-acceptance of the application form. The making of false or misleading statements or the withholding of relevant information in respect of this application may result in criminal prosecution, denial of this application and/or withdrawal of any medical certificate(s) granted.

1. LICENSING AUTHORITY: State name of country this application is to be forwarded to. 2. MEDICAL CERTIFICATE APPLIED FOR: Tick appropriate box □ Class 1: Professional Pilot □ Class 2: Private Pilot □ LAPL

3. SURNAME: State surname/family name. 4. PREVIOUS SURNAME(S): If your surname or family name has changed for any reason, state previous name(s). 5. FORENAME(S): State first and middle names (maximum three). 6. DATE OF BIRTH: Specify in order dd/mm/yyyy. 7. SEX: Tick appropriate box. 8. PLACE AND COUNTRY OF BIRTH: State town and country of birth. 9. NATIONALITY: State name of country of citizenship. 10. PERMANENT ADDRESS: State permanent postal address and country. Enter telephone area code as well as telephone number. 11. POSTAL ADDRESS (IF DIFFERENT): If different from permanent address, state full current postal address including telephone number and area code. If the same, enter ‘SAME’. 12. APPLICATION: Tick appropriate box. 13. REFERENCE NUMBER: State reference number allocated to you by the licensing authority. Initial applicants enter ‘NONE’.

14. TYPE OF LICENCE APPLIED FOR: State type of license applied for from the following list:

□ Airplane Transport Pilot License

□ Multi-Pilot license

□ Commercial Pilot license/Instrument Rating

□ Commercial Pilot license

□ Private Pilot license/Instrument Rating

□ Private Pilot license

□ Sailplane Pilot license

□ Balloon Pilot license

□ Light Aircraft Pilot license

□ And whether Fixed Wing / Rotary Wing / Both

□ Other – Please specify

15. OCCUPATION (PRINCIPAL): Indicate your principal employment. 16. EMPLOYER: If principal occupation is pilot, then state employer’s name or if self-employed, state ‘self’. 17. LAST APPLICATION FOR A MEDICAL CERTIFICATE: State date (day, month, year) and place (town, country) Initial applicants state ‘NONE’. 18. LICENCE(S) HELD (TYPE): State type of license(s) held. Enter license number and State of issue. If no licenses are held, state ‘NONE’.

19. ANY LIMITATIONS ON THE LICENCE(S)/MEDICAL CERTIFICATE: Tick appropriate box and give details of any limitations on your license(s)/medical certificate, e.g. vision, colour vision, safety pilot, etc. 20. MEDICAL CERTIFICATE DENIAL, SUSPENSION OR REVOCATION: Tick ‘YES’ box if you have ever had a medical certificate denied, suspended or revoked, even if only temporary. If ‘YES’, state date (dd/mm/yyyy) and country where it occurred. 21. FLIGHT TIME TOTAL: State total number of hours flown. 22. FLIGHT TIME SINCE LAST MEDICAL: State number of hours flown since your last medical examination. 23. AIRCRAFT CLASS/TYPE(S) PRESENTLY FLOWN: State name of principal aircraft flown, e.g. Boeing 737, Cessna 150, etc. 24. ANY AVIATION ACCIDENT OR REPORTED INCIDENT SINCE LAST MEDICAL EXAMINATION: If ‘YES’ box ticked, state date (dd/mm/yyyy) and country of accident/incident. 25. TYPE OF FLYING INTENDED: State whether airline, charter, single-pilot, commercial air transport, carrying passengers, agriculture, pleasure, etc. 26. PRESENT FLYING ACTIVITY: Tick appropriate box to indicate whether you fly as the SOLE pilot or not. 27. DO YOU DRINK ALCOHOL? Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 liters beer. 28. DO YOU CURRENTLY USE ANY MEDICATION?: If ‘YES’, give full details - name, how much you take and when, etc. Include any non-prescription medication. 29. DO YOU SMOKE TOBACCO? Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (e.g. 2 cigars daily; pipe – 1 oz. weekly)

GENERAL AND MEDICAL HISTORY

All items under this heading from number 101 to 179 inclusive should have the answer ‘YES’ or ‘NO’ ticked. You should tick ‘YES’ if you have ever had the condition in your life and describe the condition and approximate date in the (30) remarks section. All questions asked are medically important even though this may not be readily apparent. Items numbered 170 to 179 relate to immediate family history, whereas items numbered 150 to 151 should be answered by female applicants only. If information has been reported on a previous application form for a medical certificate and there has been no change in your condition, you may state ‘Previously reported; no change since’. However, you should still tick ‘YES’ to the condition. Do not report occasional common illnesses such as colds. 31. DECLARATION AND CONSENT TO OBTAINING AND RELEASING INFORMATION: Do not sign or date these declarations until indicated to do so by the AME who will act as witness and sign accordingly.

**Applicants Declaration, attachment to the Application form for a medical certificate**

DECLARATION

1. I'm not holding medical certificate in the same category issued in another Member State; (2) I have not applied for any medical certificate in the same category in another Member State; and (3) I have never held any medical certificate in the same category issued in another Member State which was revoked or suspended in any other Member State. CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby authorise the release of all information contained in Aplication Form and Medical Examination Report and any or all attachments to the medical assessor of the Croatian Civil Aviation Agency, recognising that these documents or electronically stored data are to be used for forwarding to the licensing authority, and for the purpose of AME/AeMC oversight. Medical Confidentiality will be respected at all times.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_