

LOGO

CIVIL AVIATION ADMINISTRATION/MEMBER STATE

APPLICATION FORM FOR A MEDICAL CERTIFICATE

MEDICAL IN CONFIDENCE

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

(1) State of licence issue:		(2) Medical certificate applied for: class 1 <input type="checkbox"/> class 2 <input type="checkbox"/> LAPL <input type="checkbox"/>	
(3) Surname:		(4) Previous surname(s):	(12) Application: Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/>
(5) Forename(s):		(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) Licence(s) held (type): Licence number: State of issue:		(19) Any limitations on licence(s)/medical certificate held No <input type="checkbox"/> Yes <input type="checkbox"/> Details:	
(20) Have you ever had a medical certificate denied, suspended or revoked by any licensing authority? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Country: Details:		(21) Flight time total:	(22) Flight time since last medical:
		(23) Aircraft class/type(s) presently flown:	
(24) Any aviation accident or reported incident since last medical examination? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Place: Details:		(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 medication, 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). If yes, give details in remarks section (30).

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			
		114 Frequent or severe headaches		125 Sexually transmitted disease		172 High cholesterol level			
103 Spectacle/contact lens prescriptions change since last medical exam.		115 Dizziness or fainting spells		126 Sleep disorder/apnoea syndrome		173 Epilepsy			
		116 Unconsciousness for any reason		127 Musculoskeletal illness/impairment		174 Mental illness			
104 Hay fever, other allergy		117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.		128 Any other illness or injury		175 Diabetes			
105 Asthma, lung disease		118 Psychological/psychiatric trouble of any sort		129 Admission to hospital		176 Tuberculosis			
106 Heart or vascular trouble		119 Alcohol/drug/substance abuse		130 Visit to medical practitioner since last medical examination		177 Allergy/asthma/eczema			
107 High or low blood pressure		120 Attempted suicide		131 Refusal of life insurance		178 Inherited disorders			
108 Kidney stone or blood in urine				132 Refusal of flying licence		179 Glaucoma			
109 Diabetes, hormone disorder		121 Motion sickness requiring medication		133 Medical rejection from or for military service		Females only:			
110 Stomach, liver or intestinal trouble		122 Anaemia/sickle cell trait/other blood disorders		134 Award of pension or compensation for injury or illness		150 Gynaecological, menstrual problems			
111 Deafness, ear disorder						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, 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 AME and, where necessary, to the medical assessor of the licensing authority, 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.

Date

Signature of applicant

Signature of AME/(GMP)/(medical assessor)

MEDICAL EXAMINATION REPORT FORM FOR CLASS 1 & CLASS 2 APPLICANTS

MEDICAL IN CONFIDENCE

(201) Examination category Initial <input type="checkbox"/> Revalidation <input type="checkbox"/> Renewal <input type="checkbox"/> Special referral <input type="checkbox"/>	(202) Height (cm)	(203) Weight (kg)	(204) Colour eye	(205) Colour hair	(206) Blood pressure-seated (mmHg) Systolic Diastolic	(207) Pulse - resting Rate (bpm) Rhythm: regular <input type="checkbox"/> irregular <input type="checkbox"/>
Clinical exam: Check each item		Normal	Abnormal	Normal	Abnormal	
(208) Head, face, neck, scalp			(218) Abdomen, hernia, liver, spleen			
(209) Mouth, throat, teeth			(219) Anus, rectum			
(210) Nose, sinuses			(220) Genito-urinary system			
(211) Ears, drums, eardrum motility			(221) Endocrine system			
(212) Eyes - orbit & adnexa; visual fields			(222) Upper & lower limbs, joints			
(213) Eyes - pupils and optic fundi			(223) Spine, other musculoskeletal			
(214) Eyes - ocular motility; nystagmus			(224) Neurologic - reflexes, etc.			
(215) Lungs, chest, breasts			(225) Psychiatric			
(216) Heart			(226) Skin, identifying marks and lymphatics			
(217) Vascular system			(227) General systemic			
(228) Notes: Describe every abnormal finding. Enter applicable item number before each comment.						

Visual acuity

(229) Distant vision at 5m/6m

	Uncorrected		Spectacles	Contact lenses
Right eye		Corr. to		
Left eye		Corr. to		
Both eyes		Corr. to		

(230) Intermediate vision N14 at 100 cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(231) Near vision N5 at 30-50 cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(232) Spectacles (233) Contact lenses

Yes No Yes No

Type: _____ Type: _____

Refraction	Sph	Cyl	Axis	Add
Right eye				
Left eye				

(313) Colour perception Normal Abnormal

Pseudo-isochromatic plates Type: Ishihara (24 plates)

No of plates: _____ No of errors: _____

(234) Hearing (when 239/241 not performed)

	Right ear	Left ear
Conversational voice test (2m) with back turned to examiner	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Audiometry

Hz	500	1000	2000	3000
Right				
Left				

(249) AME declaration:

I hereby certify that I/my AME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

(250) Place and date:	AME name and address:	AME certificate No.:
AME signature:	E-mail: Telephone No.: Telefax No.:	

(236) Pulmonary function

(237) Haemoglobin

FEV₁/FVC _____ % _____ (unit)

Normal Abnormal Normal Abnormal

(235) Urinalysis Normal Abnormal

Glucose	Protein	Blood	Other

Accompanying reports

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) AME recommendation:

Name of applicant: _____ Date of birth: _____ Reference number: _____

Fit for class: _____

Medical certificate issued by undersigned (copy attached) for class: _____

Unfit for class: _____

Deferred for further evaluation. If yes, why and to whom?

(248) **Comments, limitations**

Shaded areas do not require completion

MEDICAL EXAMINATION REPORT FORM FOR LAPL APPLICANTS

MEDICAL IN CONFIDENCE

(201) Examination category Initial <input type="checkbox"/> Revalidation <input type="checkbox"/> Renewal <input type="checkbox"/> Special referral <input type="checkbox"/>	(202) Height (cm)	(203) Weight (kg)	(204) Colour eye	(205) Colour hair	(206) Blood pressure-seated (mmHg) Systolic Diastolic	(207) Pulse - resting Rate (bpm) Rhythm: regular <input type="checkbox"/> irregular <input type="checkbox"/>
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Clinical exam: Check each item		Normal	Abnormal	Normal	Abnormal
(208) Head, face, neck, scalp				(218) Abdomen, hernia, liver, spleen	
(209) Mouth, throat, teeth				(219) Anus, rectum	
(210) Nose, sinuses				(220) Genito-urinary system	
(211) Ears, drums, eardrum motility				(221) Endocrine system	
(212) Eyes - orbit & adnexa; visual fields				(222) Upper & lower limbs, joints	
(213) Eyes - pupils and optic fundi				(223) Spine, other musculoskeletal	
(214) Eyes - ocular motility; nystagmus				(224) Neurologic - reflexes, etc.	
(215) Lungs, chest, breasts				(225) Psychiatric	
(216) Heart				(226) Skin, identifying marks and lymphatics	
(217) Vascular system				(227) General systemic	
(228) Notes: Describe every abnormal finding. Enter applicable item number before each comment.					

Visual acuity
(229) Distant vision at 5m/6m

	Uncorrected		Spectacles	Contact lenses
Right eye		Corr. to		
Left eye		Corr. to		
Both eyes		Corr. to		

(230) Intermediate vision
N14 at 100 cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(231) Near vision
N5 at 30-50 cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(232) Spectacles Yes No (233) Contact lenses Yes No

Type: _____ Type: _____

Refraction	Sph	Cyl	Axis	Add
Right eye				
Left eye				

(313) Colour perception Normal Abnormal

Pseudo-isochromatic plates Type: Ishihara (24 plates)
No of plates: _____ No of errors: _____

(234) Hearing (when 239/241 not performed)

	Right ear	Left ear
Conversational voice test (2m) with back turned to examiner	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Audiometry

Hz	500	1000	2000	3000
Right				
Left				

(236) Pulmonary function (237) Haemoglobin

FEV ₁ /FVC _____ % Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	_____ (unit) Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
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(235) Urinalysis Normal Abnormal

Glucose	Protein	Blood	Other

Accompanying reports

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) AME/GMP recommendation:

Name of applicant: _____ Date of birth: _____ Reference number: _____

Fit for medical certificate for LAPL
 Medical certificate issued by undersigned (copy attached) for LAPL
 Unfit for class: _____
 Deferred for further evaluation. If yes, why and to whom?

(248) **Comments, limitations**

(249) AME/GMP declaration:
I hereby certify that I have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

(250) Place and date:	AME/GMP name and address:	AME certificate No./GMP identification No.:
AME/GMP signature:	E-mail: Telephone No.: Telefax No.:	

OPHTHALMOLOGY EXAMINATION REPORT FORM

Complete this page fully and in block capitals – Refer to instructions for completion.

MEDICAL IN CONFIDENCE

Applicant's details

(1) State applied to:	(2) Medical certificate applied for: class 1 <input type="checkbox"/> class 2 <input type="checkbox"/>	
(3) Surname:	(4) Previous surname(s):	(12) Application: Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/>
(5) Forename(s):	(6) Date of birth:	(7) Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
(13) Reference number:		
(301) 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 AME and, where necessary, to the medical assessor of the licensing authority, 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.		
..... Date Signature of applicant Signature of AME

(302) Examination category:	(303) Ophthalmological history:
Initial <input type="checkbox"/>	
Revalidation <input type="checkbox"/>	
Renewal <input type="checkbox"/>	
Special referral <input type="checkbox"/>	

Clinical examination

Check each item	Normal	Abnormal
(304) Eyes, external & eyelids		
(305) Eyes, Exterior (slit lamp, ophth.)		
(306) Eye position and movements		
(307) Visual fields (confrontation)		
(308) Pupillary reflexes		
(309) Fundi (Ophthalmoscopy)		
(310) Convergence	cm	
(311) Accommodation	D	

(312) *Ocular muscle balance* (in prisme dioptres)

Distant at 5m/6m	Near at 30-50 cm
Ortho	Ortho
Eso	Eso
Exo	Exo
Hyper	Hyper
Cyclo	Cyclo
Tropia Yes No	Phoria Yes No
Fusional reserve testing Not performed	Normal Abnormal

(313) *Colour perception*

Pseudo-Isochromatic plates	Type: Ishihara (24 plates)
No of plates:	No of errors:
Advanced colour perception testing indicated	Yes No
Method:	
Colour SAFE	Colour UNSAFE

Visual acuity

(314) <i>Distant vision at 5m/6m</i>		Spectacles	Contact lenses
Uncorrected			
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		
(315) <i>Intermediate vision at 1m</i>		Spectacles	Contact lenses
Uncorrected			
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		
(316) <i>Near vision at 30-50cm</i>		Spectacles	Contact lenses
Uncorrected			
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		

(317) *Refraction*

	Sph	Cylinder	Axis	Near (add)
Right eye				
Left eye				
Actual refraction examined Spectacles prescription based				

(318) *Spectacles*

Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Type:	Type:

(319) *Contact lenses*

Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Type:	Type:

(320) *Intra-ocular pressure*

Right (mmHg)	Left (mmHg)
Method	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

(321) **Ophthalmological remarks and recommendation:**

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(322) **Examiner's declaration:**

I hereby certify that I/my AME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.		
(323) Place and date:	Ophth examiner's name and address: (block capitals)	AME or specialist stamp with No.:
AME signature:	E-mail: Telephone No.: Telefax No.:	

OTORHINOLARYNGOLOGY EXAMINATION REPORT FORM

Complete this page fully and in block capitals – Refer to instructions for completion.

MEDICAL IN CONFIDENCE

Applicant's details

(1) State applied to:	(2) Medical certificate applied for:	class 1 <input type="checkbox"/>	class 2 <input type="checkbox"/>
(3) Surname:	(4) Previous surname(s):	(12) Application:	Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/>
(5) Forename(s):	(6) Date of birth:	(7) Sex:	(13) Reference number:
		Male <input type="checkbox"/> Female <input type="checkbox"/>	
(401) 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 AME and, where necessary, to the medical assessor of the licensing authority, recognising that these documents, or any 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	

(402) Examination category:	(403) Otorhinolaryngological history:
Initial <input type="checkbox"/>	
Special referral <input type="checkbox"/>	

Clinical examination

Check each item	Normal	Abnormal
(404) Head, face, neck, scalp		
(405) Buccal cavity, teeth		
(406) Pharynx		
(407) Nasal passages and naso-pharynx (incl. anterior rhinoscopy)		
(408) Vestibular system incl. Romberg test		
(409) Speech		
(410) Sinuses		
(411) Ext acoustic meati, tympanic membranes		
(412) Pneumatic otoscopy		
(413) Impedance tympanometry including Valsalva manoeuvre (initial only)		

(419) Pure tone audiometry

Hz	dB HL (hearing level)	
	Right ear	Left ear
250		
500		
1000		
2000		
3000		
4000		
6000		
8000		

(420) Audiogram

dB/HL	o = Right		---- = Air	 = Bone			
	x = Left							
-10								
0								
10								
20								
30								
40								
50								
60								
70								
80								
90								
100								
110								
120								
Hz	250	500	1000	2000	3000	4000	6000	8000

Additional testing (if indicated)	Not performed	Normal	Abnormal
(414) Speech audiometry			
(415) Posterior rhinoscopy			
(416) EOG; spontaneous and positional nystagnus			
(417) Differential caloric test or vestibular autorotation test			
(418) Mirror or fibre laryngoscopy			

(421) Otorhinolaryngology remarks and recommendation:

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(422) Examiner's declaration:

I hereby certify that I/my AME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.		
(423) Place and date:	ORL examiner's name and address: (block capitals)	AME or specialist stamp with No:
AME signature:	E-mail: Telephone No.: Telefax No.:	