

Complete this page fully and in block capitals – Refer to instruction pages for details.

Medical in confidence

1. JAA State of licence issue:		2. Class of medical certificate applied for: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> Others	
3. Surname:		4. Previous surname(s):	
5. Forenames:		7. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Place and country of birth:		9. Nationality:	
10. Permanent address: Country: E-mailaddress: Telephone No:		11. Postal address (if different): Country: Telephone No:	
18. Aviation licence(s) held (type):		Licence number:	
		Country of issue:	
20. Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: Country: Details:		12. Application: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal/Revalidation	
		13. Reference number:	
		14. Type of licence applied for:	
		15. Occupation (principal):	
		16. Employer:	
		17. Last medical application: Date: Place:	
19. Any Limitations on the Licence/Medical Certificate: <input type="checkbox"/> No <input type="checkbox"/> Yes Details:		21. Total flight time hours:	
		22. Flight time hours since last medical:	
		23. Aircraft presently flown:	
24. Any aircraft accident or reported incident since last medical? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: Place: Details:		25. Type of flying intended:	
		26. Present flying activity: <input type="checkbox"/> Single-pilot <input type="checkbox"/> Multi-pilot	
27. Alcohol - state average weekly intake in units:		28. Do you currently use any medication? <input type="checkbox"/> No <input type="checkbox"/> Yes 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? 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
101. Eye trouble/Eye operation?				114. Frequent or severe headaches?				125. Sexually transmitted disease?				Females only:			
102. Spectacles and/or contact lenses ever worn?				115. Dizziness or fainting spells?				126. Admission to hospital?				150. Gynaecological, or menstrual problems?			
103. Spectacles/contact lenses prescriptions change since last medical exam.?				116. Unconsciousness for any reason?				127. Any other illness or injury?				151. Are you pregnant?			
104. Hay fever or other allergy?				117. Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.?				128. Visit to medical practitioner since last medical examination?				Family history of:			
105. Asthma or lung disease?				118. Psychological/psychiatric trouble of any sort?				129. Refusal of life insurance?				170. Heart disease?			
106. Heart or vascular trouble?				119. Alcohol/drug/substance abuse?				130. Refusal of flying licence?				171. High blood pressure?			
107. High or low blood pressure?				120. Attempted suicide?								172. High cholesterol level?			
108. Kidney stone or blood in urine?				121. Motion sickness requiring medication?				132. Medical rejection from or for military service?				173. Epilepsy?			
109. Diabetes, hormone disorder?				122. Anaemia/Sickle cell trait/other blood disorder?				133. Award of pension or compensation for injury or illness?				174. Mental illness?			
110. Stomach, liver or intestinal trouble?				123. Malaria or other tropical disease?								175. Diabetes?			
111. Deafness, ear disorder?				124. A positive HIV test?								176. Tuberculosis?			
112. Nose, throat or speech disorder?												177. Allergy, asthma or eczema?			
113. Head injury or concussion?												178. Inherited disorders?			
												179. Glaucoma?			

 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 State, recognising that these documents or any other 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.

L 1652-3

_____	_____	_____
Date	Signature of applicant	Signature of AME (Witness)

MEDICAL EXAMINATION REPORT

201. Examination <input type="checkbox"/> Initial <input type="checkbox"/> Renew/Reval <input type="checkbox"/> Extended	202. Height cm	203. Weight kg	204. Eye colour	205. Hair colour	206. Blood Pressure-seated Systolic Diastolic	207. Pulse-resting Rate Rhythm
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Clinical examination: Check each item Normal Abnormal Normal Abnormal

208. Head, face, neck, scalp	Normal	Abnormal	218. Abdomen, hernia, liver, spleen	Normal	Abnormal
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 Spec- Contact-
(229) Distant vision at 5m/6m tacles lenses

Right eye	Uncorrected		Corrected to		
Left eye	Uncorrected		Corrected to		
Both eyes	Uncorrected		Corrected to		

(230) Intermediate vision

	Uncorrected		Corrected		
N14 at 100 cm	Yes	No	Yes	No	
Right eye					
Left eye					
Both eyes					

(231) Near vision

	Uncorrected		Corrected		
N5 at 30-50 cm	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				

246. Colour perception

Pseudo-isochromatic plates Type:

No of plates: No of errors:

(234) Hearing (when 241 not performed)

	Right ear	Left ear		
Conversational voice test at 2 m back turned to examiner	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Audiometry				
Hz	500	1000	2000	3000
Right				
Left				

249. Medical 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.

250. Place and date:	Examiner's Name and Address: (Block Capitals)	AME Stamp with AME No:
Authorised Medical Examiner's Signature:	E-mail:	
	Telephone No:	
	Telefax No:	

(236) Pulmonary function (237) Haemoglobin

Peak Expiratory Flow l/min g/dl

Normal Abnormal Normal Abnormal

(235) Urinalysis Normal Abnormal

Glucose	Protein	Blood	Other
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Accompanying Reports Not performed Normal Abnormal

238. ECG	Not performed	Normal	Abnormal
239. Audiogram			
240. Ophthalmology			
241. ORL (ENT)			
242. Chest X-ray			
243. Blood lipids			
244. Pulmonary function			
245. EEG			
246. Other (No)			

247. Aviation medical examiner's recommendation:

Name of applicant: Date of birth:

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Fit class

Medical certificate issued by undersigned (copy attached) class

Unfit class (JAR-FCL para.....)

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

248. Comments, restrictions, limitations:

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