

<b>Applicant</b>		
<b>1.1 Applicant Data</b>		
1.1.1 Customer Number		
1.1.2 Applicant Name (name of AeMC)		
<b>1.1.3 Address</b> (registered business address)	Street / Nr	
	Post Code	
	City	
	Country	
<b>1.1.4 Contact Person</b> (responsible for this application)	Title	
	Name	
	First name	
	Function	
	Phone	
	Email	
<b>1.2 Aero-medical Centre</b> (for which approval is requested)	<input type="checkbox"/> Same as Applicant Data in section 1.1 (→ continue with section 1.3)	
<b>1.2.1 Scope of approval applied for (aircrew, ATCO or both)</b>	<input type="checkbox"/> Regulation (EU) 1178/2011 <input type="checkbox"/> Regulation (EU) 2015/340	
<b>1.2.1 Aero-medical Centre Name</b>	<input type="checkbox"/> Same as in section 1.1.2 Applicant Name	<input type="checkbox"/> Other (please specify below)
	Name	
<b>1.2.2 Aero-medical Centre Address</b>	<input type="checkbox"/> Same as in section 1.1.3 Address	<input type="checkbox"/> Other (please specify below)
	Street / Nr	
	Post Code	
	City	
	Country	
<b>1.2.3 Use Annex I</b> to list all medical and technical facilities related to the scope of approval including auxiliary clinical sites. (if different from 1.2)		
<b>1.2.4 Use Annex II</b> to list all medical and technical equipment related to the scope of approval, including at auxiliary clinical sites listed in 1.2.3		

<b>1.3 Billing Data</b>		<input type="checkbox"/> Same as Applicant Data in section 1.1 (→ continue with section 1.4)	
<b>1.3.1 Applicant Name</b>	<input type="checkbox"/> Same as in section 1.1.2 Applicant Name		<input type="checkbox"/> Other (please specify below)
	Name		
<b>1.3.2 Billing Address</b>	<input type="checkbox"/> Same as in section 1.1.3 Address		<input type="checkbox"/> Other (please specify below)
	Street / Nr		
	PO Box		
	Post Code		
	City		
	Country		
<b>1.3.3 Contact Person (Financial)</b>	<input type="checkbox"/> Same as in section 1.1.4 Contact Person		<input type="checkbox"/> Other (please specify below)
	Title	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	
	Name		
	First name		
	Function		
	Phone		
<b>1.4 Certificate Delivery Data</b>		<input type="checkbox"/> Same as Applicant Data in section 1.1	
<b>1.4.1 Applicant Name</b>	<input type="checkbox"/> Same as in section 1.1.2 Applicant Name		<input type="checkbox"/> Other (please specify below)
	Name		
<b>1.4.2 Delivery Address</b>	<input type="checkbox"/> Same as in section 1.1.3 Address		<input type="checkbox"/> Other (please specify below)
	Street / Nr		
	PO Box		
	Post Code		
	City		
	Country		
<b>1.4.3 Contact Person (Certificate Delivery)</b>	<input type="checkbox"/> Same as in section 1.1.4 Contact Person		<input type="checkbox"/> Other (please specify below)
	Title	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	
	Name		
	First name		
	Function		
	Phone		
	Email		

<b>Applicant's Reference</b> Please provide an individual reference to this application		
<b>Identification of Activity</b>		
<input type="checkbox"/> Initial Approval		
<input type="checkbox"/> Change Approval	NAA Approval N°:	
<b>Intended commencement of activity on</b>	(dd Month yyyy)	
<b>2. Head of AeMC and Accountable Manager</b>		
<b>2.1 Names</b>		
<b>2.2 AME certificate reference (if relevant)</b>		
<b>2.3 Class 1 privilege since (if relevant)</b>	(dd Month yyyy)	
<b>3. Name of qualified AME(s)</b> Use Annex III to list all qualified AMEs, other medical staff and supporting specialist consultants.		
<b>4. Proposed administration documents and manuals submitted with application</b>		
<input type="checkbox"/> Management System documentation <input type="checkbox"/> Documents of clinical attachment, or liaison with designated hospitals, or medical institutes <input type="checkbox"/> Head of AeMC CV <input type="checkbox"/> Nominated Safety Manager (SM) and related CV <input type="checkbox"/> Staff Training Records		
<input type="checkbox"/> Procedure for attachment of medical files to the system designated by the competent authority <input type="checkbox"/> Other relevant documentation related to ORA.GEN or ORA.AeM <input type="checkbox"/> Emergency response plan <input type="checkbox"/> Application for derogation according to IS.I/D.OR.200 (e)		
<b>5. Details of proposed compliance monitoring system</b>		
<b>Item</b>	<b>Reference in the organisation's documentation</b>	
5.1 Detailed description of the compliance monitoring function of the management system	Please enter the reference in your organisation's documentation	
5.2 List, table or cross-reference indicating what means and methods are dedicated to achieve initial and continued compliance with each implemented requirement applicable to the organisation	Please enter the reference in your organisation's documentation	
5.3 Means and methods establishing the internal audit process	Please enter the reference in your organisation's documentation	
5.4 Means and methods establishing the feedback system of audit findings to the accountable manager	Please enter the reference in your organisation's documentation	
5.5 Nominated person or group of persons, ultimately responsible to the accountable manager of ensuring	Please enter the reference in your organisation's documentation	

that the organisation remains in compliance with the applicable requirements (CMM)	
5.6 Means and methods making personnel aware of their responsibilities	Please enter the reference in your organisation's documentation
5.7 Procedure for amending the documentation	Please enter the reference in your organisation's documentation
5.8 Means and methods to ensure initial and continued compliance of contracted activities	Please enter the reference in your organisation's documentation
5.9 Compliance with the requirement for the direct safety accountability of the accountable manager	Please enter the reference in your organisation's documentation
5.10 Compliance with the requirement for the organisation's safety policy	Please enter the reference in your organisation's documentation
5.11 Compliance with the requirement for the identification of aviation safety hazards entailed by the activities of the organisation (in terms of means and methods)	Please enter the reference in your organisation's documentation
5.12 Compliance with the requirement for the evaluation and the management of risks associated with the identified aviation safety hazards (in terms of means and methods)	Please enter the reference in your organisation's documentation
5.13 Compliance with the requirement for the actions to be taken to mitigate the risk and verify their effectiveness (in terms of means and methods)	Please enter the reference in your organisation's documentation
5.14 Compliance with the requirement for making personnel aware of their responsibilities as regards the safety functions (in terms of means and methods)	Please enter the reference in your organisation's documentation

## 6. Notes

If answers to any of the above questions are incomplete: Please provide full details of alternative arrangements separately.

It follows from section 2 of the Regulation (1994:1808) on competent authorities in the area of civil aviation, that the Swedish Transport Agency shall issue and renew the certificates of aero-medical centres located inside the territory of Sweden.  
Therefore please enclose with this application a copy of your Certificate of Incorporation (for profit organisations) or the equivalent official document (for non-profit organisations) confirming the legal status of your organisation.

**7. Applicant's declaration and acceptance of the General Conditions and Terms of Payment**

I declare that I have the legal capacity to submit this application to the Swedish Transport Agency (STA) and that all information provided in this application form is correct and complete.

I have understood that I am submitting an application for which fees or charges will be levied in accordance with the Swedish Transport Agency Regulation (TSFS 2016:105) on charges, available from [Transportstyrelsens föreskrifter \(TSFS 2016:105\) om avgifter, konsoliderad elektronisk utgåva](#).

I, the undersigned, on behalf of the applicant identified in 1.1.2 above certify that all the above named persons are in compliance with the applicable requirements and that all the above information given is complete and correct. Furthermore, I am aware of my responsibility that this organisation fully complies with the national directives and guidelines for aeromedical examiners and aeromedical centres in Sweden and also communicate decisions from the STA directly to the applicant.

Date/Place	Name of Accountable Manager	Signature

This Application with Annexes I-III and the additional document as outlined in Chapter 6 should be sent by e-mail or regular mail to:

Swedish Transport Agency  
Maritime and Civil Aviation Department  
Personnel and Qualification Unit  
Licensing Section  
SE-601 73 NORRKÖPING  
SWEDEN

E-mail: [luft.medicin@transportstyrelsen.se](mailto:luft.medicin@transportstyrelsen.se)

**PLEASE DO NOT FORGET TO SIGN THE APPLICATION FORM**

List of medical and technical facilities including auxiliary clinical sites.		
Medical & technical facilities related to scope of approval & auxiliary clinical sites.		Type of Activity
1.	Name	<input type="checkbox"/> Clinical attachment <input type="checkbox"/> for initial class 1
	Street / Nr	
	PO Box	
	Post Code	
	City	
	Country	
2.	Name	<input type="checkbox"/> Clinical attachment <input type="checkbox"/> for initial class 1
	Street / Nr	
	PO Box	
	Post Code	
	City	
	Country	
3.	Name	<input type="checkbox"/> Clinical attachment <input type="checkbox"/> for initial class 1
	Street / Nr	
	PO Box	
	Post Code	
	City	
	Country	
4.	Name	<input type="checkbox"/> Clinical attachment <input type="checkbox"/> for initial class 1
	Street / Nr	
	PO Box	
	Post Code	
	City	
	Country	
5.	Name	<input type="checkbox"/> Clinical attachment <input type="checkbox"/> for initial class 1
	Street / Nr	
	PO Box	
	Post Code	
	City	
	Country	

*Insert additional lines if necessary*

..List of medical and technical equipment, including procedures at AeMC and auxiliary clinical sites.			
		AeMC	Auxiliary site
1. General medical practice			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiology			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
3. Ophthalmology			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
5. Otorhinolaryngology			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>



		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**Annex III:**List of qualified AMEs, other medical staff and supporting specialist consultants

		Identification and qualifications	Certificate & role	Type of Employment
1.	Name		Certificate Number:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
	Qualifications		<input type="checkbox"/> AME <input type="checkbox"/> Supporting specialist consultant	
2.	Name		Certificate Number:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
	Qualifications		<input type="checkbox"/> AME <input type="checkbox"/> Supporting specialist consultant	
3.	Name		Certificate Number:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
	Qualifications		<input type="checkbox"/> AME <input type="checkbox"/> Supporting specialist consultant	
4.	Name		Certificate Number:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
	Qualifications		<input type="checkbox"/> AME <input type="checkbox"/> Supporting specialist consultant	
5.	Name		Certificate Number:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
	Qualifications		<input type="checkbox"/> AME <input type="checkbox"/> Supporting specialist consultant	

*Insert additional lines if necessary*

## Completion Instructions for Application Form:

This Application Completion Instruction Sheet will provide you with any additional instructions and requirements necessary to complete the Application for an AeMC Organisation Approval. Please complete the form in a **clearly legible** way.

### Chapter 1: Applicant

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- 1.1.1 If known, please enter your Swedish Transport Agency customer number.
- 1.1.2 Please enter the full **name of the company** as it appears on the Article/Certificate of incorporation of the company. If applicable also enter the Trade Name, Doing-business-as and the Company registration number. In case the applicant is not a company but a **natural person**, please enter the full name as it appears in your ID Card/Passport.
- 1.1.3 Please enter the address of the registered office as it appears on the Article/Certificate of incorporation of the company. In case the applicant is not a company but a natural person, please enter the address at which you are registered.
- 1.1.4 The name and contact details specified in this section are those of the person responsible for the application.
- 1.2.1 The (company) name specified in this section will be printed on the certificate the Swedish Transport Agency will issue.
- 1.2.2 The address specified in this section, the registered business address, will be printed on the certificate the Swedish Transport Agency will issue.
- 1.3.1 The (company) name specified in this section will be printed on the invoice/s the Swedish Transport Agency will issue.
- 1.3.2 The address specified in this section will be printed on the invoice/s the Swedish Transport Agency will issue.
- 1.3.3 The name and contact details specified in this section are those of the person that will be contacted for all issue connected with the Swedish Transport Agency invoices. (e.g. accounts payable clerk)
- 1.4.1 The (company) name specified in this section is where the Swedish Transport Agency will send the original certificate/approval.
- 1.4.2 The address specified in this section is where the Swedish Transport Agency will send the original certificate/approval.
- 1.4.3 The contact person of this section is the person the approval will be sent to.

**Applicant's Reference:** IMPORTANT: Please provide an individual internal reference to this application which you would like to see on all communication with the Swedish Transport Agency.

### Chapter 2. to 5.

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- 2.1 Please provide the First Name and the surname of Head of AeMC
- 2.2 Reference of AME Certificate of the Head of AeMC
- 2.3 Date when AME Certificate of the Head of AeMC was extended to class 1 privileges
- 3. Please list in Annex III all qualified AMEs, other medical staff and supporting specialist consultants. This list shall match the lists in the manuals of the organisation.
- 4. Tick each relevant box to indicate if the document is joined to the application form.
- 5. Do not forget to provide the copy of your Certificate of Incorporation or the equivalent official document confirming the legal status of your organisation.
- 6. Please make sure that the Accountable Manager signs the application form.