

APPLICATION FORM FOR A MEDICAL CERTIFICATE

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

MEDICAL IN CONFIDENCE

(1) State of license issue: <input type="text"/> (3) Surname: <input type="text"/> (5) Forename(s): <input type="text"/> (8) Place and country of birth: <input type="text"/> (10) Permanent address: <input type="text"/> Country: <input type="text"/> Telephone No: <input type="text"/> Mobile No: <input type="text"/> E-mail: <input type="text"/> (18) License(s) held (type): <input type="text"/> License number: <input type="text"/> State of issue: <input type="text"/> (20) Have you ever had a medical certificate denied, suspended or revoked by any licensing authority? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: <input type="text"/> Country: <input type="text"/> Details: <input type="text"/> (24) Any aviation accident or reported incident since last medical examination? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: <input type="text"/> Place: <input type="text"/> Details: <input type="text"/> (27) Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, amount <input type="text"/> (29) Do you smoke tobacco? <input type="checkbox"/> No, never <input type="checkbox"/> No, date stopped: <input type="text"/> <input type="checkbox"/> Yes, state type and amount: <input type="text"/>	(2) Medical certificate applied for: CC <input type="checkbox"/> class 1 <input type="checkbox"/> class 2 <input type="checkbox"/> LAPL <input type="checkbox"/> class 3 <input type="checkbox"/> (4) Previous surname(s): <input type="text"/> (12) Application: Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/> (6) Date of Birth All dates = (ddmmyyyy): <input type="text"/> (7) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female (13) Reference number: <input type="text"/> (9) Nationality: <input type="text"/> (14) Type of license applied for: <input type="text"/> (11) Postal address (if different): <input type="text"/> Country: <input type="text"/> Telephone No.: <input type="text"/> (15) Occupation (principal): <input type="text"/> (16) Employer: <input type="text"/> (17) Last medical examination: Date: <input type="text"/> Place: <input type="text"/> (19) Any limitations on license(s)/medical certificate held. <input type="checkbox"/> No <input type="checkbox"/> Yes Details: <input type="text"/> (21) Flight time total: <input type="text"/> (22) Flight time since last medical: <input type="text"/> (23) Aircraft class/type(s) presently flown: <input type="text"/> (25) Type of flying intended: <input type="text"/> (26) Present flying activity: Single pilot <input type="checkbox"/> Multi pilot <input type="checkbox"/> (28) Do you currently use any medication? <input type="checkbox"/> No <input type="checkbox"/> Yes State medication, dose, date started and why: <input type="text"/>
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General and medical history: Do you have, or have you ever had, any of the following? Please tick (X) and if yes, give details in remarks section (30)

	Yes	No		Yes	No		Yes	No	Family history of:	Yes	No
101 Eye trouble/eye operation	<input type="checkbox"/>	<input type="checkbox"/>	112 Nose, throat or speech disorder	<input type="checkbox"/>	<input type="checkbox"/>	123 Malaria or other tropical disease	<input type="checkbox"/>	<input type="checkbox"/>	170 Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
102 Spectacles and/or contact lenses ever worn	<input type="checkbox"/>	<input type="checkbox"/>	113 Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	124 A positive HIV test	<input type="checkbox"/>	<input type="checkbox"/>	171 High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
103 Spectacle/contact lens prescriptions change since last medical exam.	<input type="checkbox"/>	<input type="checkbox"/>	114 Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	125 Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	172 High cholesterol level	<input type="checkbox"/>	<input type="checkbox"/>
			115 Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	126 Sleep disorder/apnoea syndrome	<input type="checkbox"/>	<input type="checkbox"/>	173 Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
104 Hay fever, other allergy	<input type="checkbox"/>	<input type="checkbox"/>	117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.	<input type="checkbox"/>	<input type="checkbox"/>	127 Musculoskeletal illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>	174 Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
105 Asthma, lung disease	<input type="checkbox"/>	<input type="checkbox"/>				128 Any other illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	175 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
106 Heart or vascular trouble	<input type="checkbox"/>	<input type="checkbox"/>	118 Psychological/psychiatric trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	129 Admission to hospital	<input type="checkbox"/>	<input type="checkbox"/>	176 Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
107 High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>				130 Visit to medical practitioner since last medical examination	<input type="checkbox"/>	<input type="checkbox"/>	177 Allergy/asthma/eczema	<input type="checkbox"/>	<input type="checkbox"/>
108 Kidney stone or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	119 Alcohol/drug/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	131 Refusal of life insurance	<input type="checkbox"/>	<input type="checkbox"/>	178 Inherited disorders	<input type="checkbox"/>	<input type="checkbox"/>
109 Diabetes, hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>	120 Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	132 Refusal of flying licence	<input type="checkbox"/>	<input type="checkbox"/>	179 Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
110 Stomach, liver or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	121 Motion sickness requiring medication	<input type="checkbox"/>	<input type="checkbox"/>	133 Medical rejection from or for military service	<input type="checkbox"/>	<input type="checkbox"/>	Females only:		
111 Deafness, ear disorder	<input type="checkbox"/>	<input type="checkbox"/>	122 Anaemia/sickle cell trait/other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	134 Award of pension or compensation for injury or illness	<input type="checkbox"/>	<input type="checkbox"/>	150 Gynaecological, menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
						151 Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			

(30) Remarks: If previously reported and no change since, so state.

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(31) Declaration (Samtykkeerklæring) concerning medical information:

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 my licensing authority, to the medical assessor of the competent authority of my AME and to relevant medical professionals for the purpose of completion of an aero-medical assessment or a secondary review, 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.

NOTIFICATION OF DISCLOSURE OF PERSONAL DATA: I hereby declare that I have been informed and I understand that the data contained in my medical certificate according to ARA.MED.130 and ATCO.AR.F.005 may be electronically stored and made available to my AME in order to provide historical data required in MED.A.035(b)(2)(ii)(iii) and ATCO.MED.A.035(b)(2)(ii)(iii) and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of ARA.MED.150(c)(4), cf. ATCO.AR.F.001.

Date

Signature of applicant

Signature of AME / (Medical assessor)