

Medical certificate:

 Mailed Collected from TraFi

MEDICAL IN CONFIDENCE
Please use block letters. See separate instructions.

(1) State of licence issue:	(2) Class of medical certificate applied for:	<input type="checkbox"/> Class 1 <input type="checkbox"/> LAPL <input type="checkbox"/> Cabin crew <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3
(3) Surname:	(4) Previous surname(s):	(12) Application: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal / Revalidation
(5) Forenames:	(6) Date of birth:	(7) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
(8) Place and country of birth:	(9) Nationality:	(13) Reference number:
(10) Permanent address:	(11) Postal address (if different):	(14) Type of licence applied for:
Country: _____	Country: _____	(15) Occupation (principal):
Telephone No: _____	Telephone No: _____	(16) Employer:
E-mail: _____		(17) Last medical examination: Date: _____
(18) Aviation licence(s) held (type):	Licence number:	State of issue:
		(19) Any limitations on the licence / medical certificate: <input type="checkbox"/> No <input type="checkbox"/> Yes. Details: _____
(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. Details: _____		(21) Flight time total
Date: _____ Place: _____		(22) Flight time since last medical:
(24) Any aircraft accident or reported incident since last medical examination? <input type="checkbox"/> No <input type="checkbox"/> Yes. Details: _____		(23) Aircraft class/type(s) presently flown:
Date: _____ Place: _____		(25) Type of flying intended: If flying single pilot commercial flights please mark <input type="checkbox"/> PAX for remuneration <input type="checkbox"/> PAX not for remuneration
(27) Alcohol - state average weekly intake in units:		(26) Present flying activity <input type="checkbox"/> Single pilot <input type="checkbox"/> Multi pilot
(29) Do you smoke tobacco? <input type="checkbox"/> No <input type="checkbox"/> Date stopped: _____	(28) Do you currently use any medication? <input type="checkbox"/> No <input type="checkbox"/> Yes State medication, dose, date started and why: _____	
<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).

Note: If yes, give details in remarks section (30).

	Yes	No		Yes	No		Yes	No
101 Eye trouble/eye operation	<input type="checkbox"/>	<input type="checkbox"/>	117 Neurological disorders: stroke, epilepsy, seizure, paralysis, etc.	<input type="checkbox"/>	<input type="checkbox"/>	133 Medical rejection from or for military service	<input type="checkbox"/>	<input type="checkbox"/>
102 Spectacles and/or contact lenses ever worn	<input type="checkbox"/>	<input type="checkbox"/>	118 Psychological/psychiatric trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	134 Award of pension or compensation for injury or illness	<input type="checkbox"/>	<input type="checkbox"/>
103 Spectacle/contact lens prescriptions change since last medical exam	<input type="checkbox"/>	<input type="checkbox"/>	119 Alcohol/drug/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	Females only:		
104 Hay fever, other allergy	<input type="checkbox"/>	<input type="checkbox"/>	120 Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	150 Gynaecological, menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
105 Asthma, lung disease	<input type="checkbox"/>	<input type="checkbox"/>	121 Motion sickness requiring medication	<input type="checkbox"/>	<input type="checkbox"/>	151 Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
106 Heart or vascular trouble	<input type="checkbox"/>	<input type="checkbox"/>	122 Anaemia/Sickle cell trait / other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Family history of:		
107 High or low blood pressure	<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"/>
108 Kidney stone or blood in urine	<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"/>
109 Diabetes, hormone disorder	<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"/>
110 Stomach, liver or intestinal trouble	<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"/>
111 Deafness, ear disorder	<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"/>
112 Nose, throat or speech disorder	<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"/>
113 Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	129 Admission to hospital	<input type="checkbox"/>	<input type="checkbox"/>	176 Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
114 Frequent or severe headaches	<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"/>
115 Dizziness or fainting spells	<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"/>
116 Unconsciousness for any reason	<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"/>

 (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 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 examiner, national aviation authority and, where necessary, to the Aeromedical Section (AMS) of another State, 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 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)

Instructions for completion of the application form for aviation medical certificate

Please send this application form and any accompanying report forms and reports to the aviation authority (Trafi's Transport Medicine Unit, AMS). Medical confidentiality shall be respected at all times.

The applicant must carefully fill in all boxes of the application form. Type the answers and print three identical copies of the form. Clear the form after printing. If more space is required to answer any question, write on a plain sheet of paper the applicant's name, the information, your signature and the date signed. The following instructions apply to the same numbered headings on the application form.

NOTICE: Failure to complete the medical examination report form in full as required or to write legibly may result in non acceptance of the application in total and may lead to withdrawal of any medical certificate issued. The making of false or misleading statements or the withholding of relevant information by the applicant may result in criminal prosecution, denial of an application or withdrawal of any medical certificate granted.

1. STATE APPLIED TO:

State name of country this application is to be forwarded to.

2. CLASS OF MEDICAL CERTIFICATE:

Tick appropriate box.

Class 1: Professional pilot

Class 2: Private pilot

LAPL

Class 3: Air traffic controllers and flight information service officers

Class 4: National - ultralight pilot, autogyro pilot

Cabin crew member

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. FORENAMES:

State first and middle names (maximum three).

6. DATE OF BIRTH:

Specify in order day(DD), month(MM), year(YYYY) in numerals, e.g. 22-08-1950.

7. SEX:

Tick appropriate box.

8. PLACE 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 number.

11. PERMANENT ADDRESS:

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 DESIRED:

State type of licence applied for from the following list

ATPL - Airline Transport Pilot Licence

MPL - Multi-crew Pilot Licence

CPL/IR - Commercial Pilot Licence / instrument rating

CPL - Commercial Pilot Licence

PPL/IR - Private Pilot Licence / instrument rating

PPL - Private Pilot Licence

SPL - Sailplane Pilot Licence

BPL - Balloon Pilot Licence

LAPL - Light Aircraft Pilot Licence (aeroplane/helicopter/both)

Other - Please specify

15. OCCUPATION:

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:

State type of licences held as in box 14. Enter licence number and State of issue for each licence. If no licences are held, state "NONE".

19. ANY LIMITATIONS ON THE LICENCE / MEDICAL CERTIFICATE:

Tick appropriate box and give details of any limitations on your licences / medical certificates, 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. AIRCRAFT ACCIDENT / INCIDENT

If "YES" box ticked, state date (DD/MM/YYYY) and country of accident/incident.

25. TYPE OF FLYING INTENDED:

State whether airline, charter, agriculture, pleasure, etc. If you conduct single-pilot commercial operations, state also whether you carry passengers against remuneration or not.

26. PRESENT FLYING ACTIVITY:

Tick appropriate box to indicate whether you fly as the sole pilot or not.

27. ALCOHOL

State weekly alcohol consumption e.g. 2 litres beer.

28. DO YOU CURRENTLY USE ANY MEDICATION:

If "YES", give full details - name, how much you take and when, etc. Include any nonprescription 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 must have the answer "YES" or "NO" ticked. You MUST tick "YES" if you have ever had the condition in your life and describe the condition and approximate date in item 30 Remarks box. 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 150 to 151 must be answered by female applicants only.

If information has been reported on a previous application form and there has been no change in your condition, you may state "Previously reported, no change since". However, you must 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.