



(stamp/logo of the receiver)

APPLICATION FORM FOR A MEDICAL CERTIFICATE

MEDICAL IN CONFIDENCE

Complete this page fully and in block capitals - Refer to instructions pages for details

Form with fields for personal details, medical history, and flight information. Includes sections for (1) State of licence issue, (2) Medical certificate applied for, (3) Surname, (4) Previous surname(s), (5) Forenames, (6) Date of birth, (7) Sex, (8) Place and country of birth, (9) Nationality, (10) Permanent address, (11) Postal address, (12) Application, (13) Reference number, (14) Type of licence, (15) Occupation, (16) Employer, (17) Last medical examination, (18) Aviation licence(s) held, (19) Any Limitations on Licence, (20) Have you ever had an aviation medical certificate denied, (21) Flight time hours total, (22) Flight time hours since last medical, (23) Aircraft class / type(s) presently flown, (24) Any aviation accident or reported incident, (25) Type of flying intended, (26) Present flying activity, (27) Do you drink alcohol, (28) Do you currently use any medication, (29) Do you smoke tobacco.

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).

Table with columns for YES/NO and rows for various medical conditions: 101 Eye trouble/eye operation, 102 Spectacles and/or contact lenses ever worn, 103 Spectacle/contact lens prescriptions change since last medical exam., 104 Hay fever, other allergy, 105 Asthma, lung disease, 106 Heart or vascular trouble, 107 High or low blood pressure, 108 Kidney stone or blood in urine, 109 Diabetes, hormone disorder, 110 Stomach, liver or intestinal trouble, 111 Deafness, ear disorder, 112 Nose, throat or speech disorder, 113 Head injury or concussion, 114 Frequent or severe headaches, 115 Dizziness or fainting spells, 116 Unconsciousness for any reason, 117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc, 118 Psychological/psychiatric trouble, 119 Alcohol/drug/substance abuse, 120 Attempted suicide or self-harm, 121 Motion sickness requiring medication, 122 Anaemia / Sickle cell trait/other blood disorders, 123 Malaria or other tropical disease, 124 A positive HIV test, 125 Sexually transmitted disease, 126 Sleep disorder/apnoea syndrome, 127 Musculoskeletal illness/impairment, 128 Any other illness or injury, 129 Admission to hospital, 130 Visit to medical practitioner since last medical examination, 131 Refusal of life insurance, 132 Refusal of flying licence, 133 Medical rejection from or for military service, 134 Award of pension or compensation for injury or illness, 170 Heart disease, 171 High blood pressure, 172 High cholesterol level, 173 Epilepsy, 174 Mental illness or suicide, 175 Diabetes, 176 Tuberculosis, 177 Allergy/asthma/eczema, 178 Inherited disorders, 179 Glaucoma, 150 Gynaecological, menstrual problems, 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 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 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 to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of ARA.MED.150(c)(4).

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

Remarks

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