

CIVIL AVIATION AUTHORITY

APPLICATION FORM FOR AVIATION MEDICAL CERTIFICATE

Complete this page fully using a black ball point pen and in block capitals – Refer to instructions pages for details

MEDICAL IN CONFIDENCE

(3) Surname:		(4) Previous surname(s):		Title:		(13) UK CAA Reference number:								
(5) Forenames:			(6) Date of birth:		Age:		(7) Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		(12) Application Initial <input type="checkbox"/> Renewal/Revalidation <input type="checkbox"/>					
(1) JAA State of licence issue:		(2) Class of medical certificate applied for 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> Others <input type="checkbox"/>					(14) Type of licence applied for:							
(8) Place and country of birth:			(9) Nationality:				(15) Occupation (principal)							
(10) Permanent address: Postcode Country: Telephone No.			(11) Postal address (if different) Postcode Country: Telephone No.			(16) Employer		(17) Last medical examination Date: Place:		(18) Aviation licence(s) held (type): Licence number: Country of issue:				
(500) GP Name: Address: Tel No: NHS No (optional):			(19) Any Conditions/Limitations/Variations on the Licence/Medical Certificate No <input type="checkbox"/> Yes <input type="checkbox"/> Details:											
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with AME No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ Place: _____ Details:						(21) Total flight time hours:		(22) Flight time hours since last medical:						
						(23) Aircraft presently flown (eg 737, C150 etc):								
(24) Any aircraft accident or reported incident since last medical? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ Place: _____ Details:						(25) Type of flying intended:								
						(26) Present flying activity Single pilot <input type="checkbox"/> Multi pilot <input type="checkbox"/>								
(27) Alcohol – state average weekly intake in units:				(28) Do you currently use any medication. Yes <input type="checkbox"/> No <input type="checkbox"/>				M	M	Y	Y	Y	Y	
(29) Do you smoke tobacco? Never <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Date stopped: State type, amount & number of years:				If YES, state drug, dose, date started and why										

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	Females only:		Yes	No
101 Eye trouble/eye operation			112 Nose, throat or speech disorder			123 Malaria or other tropical disease			150 Gynaecological, menstrual problems			
102 Spectacles and/or contact lenses ever worn			113 Head injury or concussion			124 A positive HIV test			151 Are you pregnant?			
103 Spectacle/contact lens prescriptions/change since last medical exam			114 Frequent or severe headaches			125 Sexually transmitted disease						
104 Hay fever, other allergy			115 Dizziness or fainting spells			126 Admission to hospital						
105 Asthma, lung disease			116 Unconsciousness for any reason			127 Any other illness or injury						
106 Heart or vascular trouble			117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			128 Visit to medical practitioner since last medical examination			Family history of:			
107 High or low blood pressure			118 Psychological/psychiatric trouble of any sort			129 Refusal of life insurance			170 Heart disease			
108 Kidney stone or blood in urine			119 Alcohol/drug/substance abuse			130 Refusal of flying licence			171 High blood pressure			
109 Diabetes, hormone disorder			120 Attempted suicide						172 High cholesterol level			
110 Stomach, liver or intestinal trouble			121 Motion sickness requiring medication			132 Medical rejection from or for military service			173 Epilepsy			
111 Deafness, ear disorder			122 Anaemia/Sickle cell trait/other blood disorders			133 Award of pension or compensation for injury or illness			174 Mental illness			
									175 Diabetes			
									176 Tuberculosis			
									177 Allergy/asthma/eczema			
									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 that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. I understand that if I have made any false or misleading statement 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 Examiner, the Authority and where necessary the Aeromedical Section of another JAA Member 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.

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

