CIVIL AVIATION AUTHORITY

APPLICATION FORM FOR AN 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 ☐ Female ☐	(12) Application Initial ☐ Revalidation/Renewal ☐
(1) JAA State of licence issue:	(2) Class of medical certificate applied for 1st ☐ 2nd ☐ Others ☐			(14) Type of licence applied for:
(8) Place and country of birth:	(9) Nationality:			(15) Occupation (principal)
(10) Permanent address: Postcode Country: Telephone No. Mobile No E-mail: @	(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: State of issue:
(500) GP Name: Address: Tel No: NHS No (optional):				(19) Any Limitations on Licence/Medical Certificate No ☐ Yes ☐ Details:
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with AME No ☐ Yes ☐ 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 ☐ Yes ☐ Date: Place: Details:				(25) Type of flying intended: (26) Present flying activity Single pilot ☐ Multi pilot ☐
(27) Do you drink alcohol – state average weekly intake in units: (29) Do you smoke tobacco? Never ☐ No ☐ Date stopped: Yes ☐ State type, amount & number of years:	(28) Do you currently use any medication. Yes ☐ No ☐ If YES, state drug, dose, date started and why		M M Y Y Y Y	

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

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Date Signature of applicant Signature of AME (Witness)

INSTRUCTION PAGE FOR COMPLETION OF THE APPLICATION FORM FOR AN AVIATION MEDICAL CERTIFICATE

This Application Form, all attached Report Forms and Reports are required in accordance with ICAO Instructions and will be transmitted to the Aeromedical Section. Medical Confidentiality shall be respected at all times.

The Applicant must personally complete in full all questions (boxes) on the Application Form. Writing must be in Block Capitals using a ball-point pen and be legible. Exert sufficient pressure to make legible copies. If more space is required to answer any question, use a plain sheet of paper bearing the information, your signature and the date signed. The following numbered instructions apply to the numbered headings on the application form.

NOTICE: Failure to complete the application form in full or to write legibly will result in non-acceptance of the application form. The making of False or Misleading statements or the Withholding of relevant information in respect of this application may result in criminal prosecution, denial of this application and/or withdrawal of any medical certificate(s) granted.

1. JAA STATE APPLIED TO: State name of Country this application is to be forwarded to.	**17. LAST MEDICAL APPLICATION:** State date (day, month, year) and place (town, country). Initial applicants state 'NONE'.
2. CLASS OF MEDICAL CERTIFICATE: Tick appropriate box. Class 1: Professional Pilot Class 2: Private Pilot Others: All other uses, e.g. ATC, Cabin Crew	**18. AVIATION LICENCE HELD:** State type of licences held as answered in Question 14. Enter licence number and State of issue for each licence. If no licences are held, state 'NONE'. 500. GP NAME: Completion of this area is optional
3. SURNAME: State Surname/ Family name.	**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.
4. PREVIOUS SURNAME(S): If your surname or family name has changed for any reason, state previous name(s).	**20. MEDICAL CERTIFICATE DENIAL OR REVOCATION:** Tick 'YES' box if you have ever had a medical certificate denied or revoked even if only temporary. If 'YES', state date (DD/MM/YYYY) and Country where occurred.
5. FORENAMES: State first and middle names (maximum three).	**21. PILOT FLIGHT TIME TOTAL:** State total number of hours flown.
6. DATE OF BIRTH: Specify in order Day(DD), Month(MM), Year(YYYY) in numerals, e.g. 22-08-1950.	**22. PILOT FLIGHT TIME SINCE LAST MEDICAL:** State number of hours flown since your last medical examination.
7. SEX: Tick appropriate box.	**23. AIRCRAFT PRESENTLY FLOWN:** State name of principal aircraft flown, e.g. Boeing 737, Cessna 150, etc.
8. PLACE OF BIRTH: State Town and Country of birth.	**24. AIRCRAFT ACCIDENT/INCIDENT:** If 'YES' box ticked, state Date (DD/MM/YYYY) and Country of Accident/Incident.
9. NATIONALITY: State name of country of Citizenship.	**25. TYPE OF FLYING INTENDED:** State whether airline, charter, single-pilot commercial air transport carrying passengers, agriculture, pleasure, etc.
10. PERMANENT ADDRESS:. State permanent postal address and country. Enter telephone area code as well as number.	**26. PRESENT FLYING ACTIVITY:** Tick appropriate box to indicate whether you fly as the SOLE pilot or not.
11. POSTAL ADDRESS: If different from permanent address, state full current postal address including telephone number and area code. If the same, enter 'SAME'.	**27. DO YOU DRINK ALCOHOL:** Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 litres beer.
12. APPLICATION: Tick appropriate box.	**28. DO YOU CURRENTLY USE ANY MEDICATION:** If 'YES', give full details - name, how much you take and when, etc. Include any non-prescription medication.
13. REFERENCE NUMBER: State Reference Number allocated to you by your National Aviation Authority. Initial Applicants enter 'NONE'.	**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)
14. TYPE OF LICENCE APPLIED FOR (OR INTENDED): State type of licence applied for from the following list: Aeroplane Transport Pilot Licence Commercial Pilot Licence/Instrument Rating Commercial Pilot Licence Private Pilot Licence/Instrument Rating Private Pilot Student Pilot And whether Fixed Wing / Rotary Wing / Both Other – Please specify	**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 the **30. REMARK**S 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 numbered 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.
15. OCCUPATION:	
16. EMPLOYER: If principal occupation is pilot, then state employer's name or if self-employed, state 'self'.	**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.

AN APPLICANT HAS THE RIGHT TO REFUSE ANY TEST AND TO REQUEST REFERRAL TO THE AUTHORITY (AMS).

HOWEVER, THIS MAY RESULT IN TEMPORARY DENIAL OF MEDICAL CERTIFICATION.