Valsts aģentūra
“Civilās aviācijas aģentūra”

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Form to be completed by the:
Applicant for or Holder of a **CLASS 1, CLASS 2, LAPL & CLASS 3 MEDICAL CERTIFICATE**
Applicant for or Holder of a **CABIN CREW MEDICAL REPORT**

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

MEDICAL IN CONFIDENCE

(1) State of licence issue:

(2) Medical certificate applied for: Class 1 Class 2 LAPL Class 3 Cabin Crew

(3) Surname:

(4) Previous surname(s):

(12) Application: Initial Revalidation / Renewal

(5) Forename(s):

(6) Date of birth (dd/mm/yyyy): ____ / ____ / __________.

(7) Sex: Male Female

(13) Reference number: n/a

(8) Place and country of birth:

(9) Nationality:

(14) Type of licence applied for:

(10) Permanent address:
Country:
Telephone No:
E-mail:

(11) Postal address (if different):
Country:
Telephone No:

(15) Occupation (principal):

(16) Employer:

(17) Latest aero-medical examination:
Date: ____ / ____ / __________.
Place:

(18) Aviation licence(s) held (type):
Licence(s) number(s): State of issue:

(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?
No Yes Date:____ / ____ / __________. Country:
Details:

(21) Flight time total:
Hrs: n/a

(22) Flight time since last aero-med. examination:
Hrs: n/a

(23) Aircraft class/type(s) presently flown: n/a

(24) Any aviation accident or reported incident since last aero-medical examination?
No n/a
Yes Date:____ / ____ / __________. Place:
Details:

(25) Type of flying intended: n/a

(26) Present flying activity: Single pilot Multi-pilot
Present ATCO activity: ADI APS ACS AFISO

(27) Do you drink alcohol?
No Yes, amount:

(28) Do you currently use any medication?
No Yes State medication, dose, date started and why:

(29) Do you smoke tobacco? No, never No, stopped, date:
Yes, type and amount:

General and medical history: Do you have, or have you ever had, any of the following? (Please tick). If yes, give details in the remarks section (30).

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

(30) **Remarks:** If previously reported and no change since, so state. Any changes since last medical examination Yes No

(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 of the Republic of Latvia.
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 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 (applies for pilots only): 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 / Medical Assessor