Valsts aģentūra "Civilās aviācijas aģentūra"
State Agency „Civil Aviation Agency" Republic of Latvia

APPLICATION FORM FOR A MEDICAL CERTIFICATE

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):

(5) Forename(s):

(6) Date of birth (dd.mm.yyyy)

(7) Sex: ☐ Male ☐ Female

(8) Place and country of birth:

(9) Nationality:

(10) Permanent address:

Phone No.:

E-Mail:

(11) Postal address (if different):

Phone No.:

(12) Application:
☐ Initial
☐ Renewal/Revalidation

(13) Medical certificate number:

EAMR ID number:

(14) Type of licence applied for:

(15) Occupation (principal):

(16) Employer:

(17) Last medical examination:
Date:
Place:
Completed: ☐ No ☐ Yes

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

(19) Any limitations on licence(s)/medical certificate held:
Details:
☐ No ☐ Yes

(20) Have you ever had medical certificate denied, suspended or revoked by any licensing authority?
☐ No ☐ Yes Date: Country:
Details:

(21) Flight time total:

(22) Flight time since last medical:

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

(24) Any aviation accident or medical event whilst exercising the privileges of the licence since the last medical examination?
☐ No ☐ Yes Date: Place:
Details:

(25) Current/intended pilot activity:
☐ Commercial ☐ Non-Commercial ☐ Other
☐ Single-pilot ☐ Multi-pilot

(26) Current/intended ATC activity:
☐ ADI ☐ APS ☐ ACS ☐ ADV ☐ APP ☐ ACP

(27) Do you drink alcohol? ☐ No ☐ Yes, state average weekly amount:
Do you use drugs ? ☐ No ☐ Yes, state the type:

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

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

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

	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 or vascular disease	☐	☐
(103) Spectacles/ 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) Sleep disorder/apnoea syndrome	☐	☐	(172) High cholesterol level	☐	☐
(105) Asthma, lung disease	☐	☐	(116) Unconsciousness for any reason	☐	☐	(127) Musculoskeletal illness/impairment	☐	☐	(173) Epilepsy	☐	☐
(106) Heart or vascular trouble	☐	☐	(117) Neurological disorders: stroke, epilepsy, seizure, paralysis etc.	☐	☐	(128) Any other illness or injury	☐	☐	(174) Mental illness or suicide	☐	☐
(107) High or low blood pressure	☐	☐	(118) Psychological/psychiatric trouble of any sort	☐	☐	(129) Admission to hospital	☐	☐	(175) Diabetes	☐	☐
(108) Kidney stone or blood in urine	☐	☐	(119) Misuse of psychoactive substances	☐	☐	(130) Visit to medical practitioner or mental health specialist since last medical examination	☐	☐	(176) Tuberculosis	☐	☐
(109) Diabetes, hormone disorder	☐	☐	(120) Attempted suicide or self-harm	☐	☐	(131) Refusal of life insurance	☐	☐	(177) Allergy/asthma/eczema	☐	☐
(110) Stomach, liver or intestinal trouble	☐	☐	(121) Motion sickness requiring medication	☐	☐	(132) Refusal of aviation licence	☐	☐	(178) Inherited disorders	☐	☐
(111) Deafness, ear disorder	☐	☐	(122) Anaemia / Sickle cell trait/ other blood disorders	☐	☐	(133) Medical rejection from or for military service	☐	☐	(179) Glaucoma	☐	☐
						(134) Award of pension or compensation for injury or illness	☐	☐	**Females only:**		
									(150) Gynaecological, menstrual problems	☐	☐
									(151) Are you pregnant?	☐	☐

(30) Remarks:

(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.

I hereby declare that I have been informed and I understand that all information provided to my AME contained in this report and its attachments and all information which is provided to my licensing authority and that relates to me, may be released to the medical assessor of my licensing authority, other health professionals and medical administration staff as part of the aero-medical assessment process and to the medical assessor of the competent authority of my AME, recognising that these documents or electronically stored data are to be used for the completion of an aero-medical assessment and for oversight purposes, providing that I or my physician may have access to them in accordance with 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 in accordance with point ARA.MED.130, or point ATCO.AR.F.005 of Regulation (EU) 2015/340 if applicable, may be electronically stored and made available to my AME in order to provide historical data required in point MED.A.035(b)(2)(ii)/(iii) or, if applicable, points ATCO.MED.A.035(b)(2)(ii) or ATCO.MED.A.035(b)(2)(iii), and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of point ARA.MED.150(c)(4).

dd.mm.yyyy	Signature of applicant	Signature of AME / medical assessor