



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:		<input type="checkbox"/> class 1	<input type="checkbox"/> class 2	<input type="checkbox"/> LAPL	<input type="checkbox"/> class 3	<input type="checkbox"/> Cabin Crew	
(3) Surname:		(4) Previous surname(s):		(12) Application: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal/Revalidation					
(5) Forename(s):		(6) Date of birth (dd.mm.yyyy)		(7) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		(13) Medical certificate number:			EAMR ID number:
(8) Place and country of birth:		(9) Nationality:		(14) Type of licence applied for:					
(10) Permanent address: Phone No.: E-Mail:		(11) Postal address (if different): Phone No.:		(15) Occupation (principal):					
(18) Licence(s) held (type): Licence number: State of issue:		(17) Last medical examination: Date: Place:		Completed: <input type="checkbox"/> No <input type="checkbox"/> Yes		(16) Employer:			
(20) Have you ever had medical certificate denied, suspended or revoked by any licensing authority? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: Country:		(19) Any limitations on licence(s)/medical certificate held: Details: <input type="checkbox"/> No <input type="checkbox"/> Yes		(21) Flight time total:		(22) Flight time since last medical:			
(24) Any aviation accident or medical event whilst exercising the privileges of the licence since the last medical examination? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: Place:		(23) Aircraft class/type(s) presently flown:		(25) Current/intended pilot activity: <input type="checkbox"/> Commercial <input type="checkbox"/> Non-Commercial <input type="checkbox"/> Other <input type="checkbox"/> Single-pilot <input type="checkbox"/> Multi-pilot					
(27) Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, state average weekly amount: Do you use drugs ? <input type="checkbox"/> No <input type="checkbox"/> Yes, state the type:		(26) Current/intended ATC activity: <input type="checkbox"/> ADI <input type="checkbox"/> APS <input type="checkbox"/> ACS <input type="checkbox"/> ADV <input type="checkbox"/> APP <input type="checkbox"/> ACP		(29) Do you smoke tobacco? <input type="checkbox"/> No, never <input type="checkbox"/> No, date stopped: <input type="checkbox"/> Yes, state type and amount:					
(28) Do you currently use any medication <input type="checkbox"/> No <input type="checkbox"/> Yes State medication, dose, date started and why:									

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	<input type="checkbox"/>	<input type="checkbox"/>	(112) Nose, throat or speech disorder	<input type="checkbox"/>	<input type="checkbox"/>	(123) Malaria or other tropical disease	<input type="checkbox"/>	<input type="checkbox"/>	Family history of: (170) Heart or vascular 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 Females only: (150) Gynaecological, menstrual problems (151) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
(102) Spectacles and/or contact lenses ever worn	<input type="checkbox"/>	<input type="checkbox"/>	(113) Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	(124) A positive HIV test	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(103) Spectacles/ contact lens prescriptions change since last medical exam.	<input type="checkbox"/>	<input type="checkbox"/>	(114) Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	(125) Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(104) Hay fever, other allergy	<input type="checkbox"/>	<input type="checkbox"/>	(115) Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	(126) Sleep disorder/apnoea syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(105) Asthma, lung disease	<input type="checkbox"/>	<input type="checkbox"/>	(116) Unconsciousness for any reason	<input type="checkbox"/>	<input type="checkbox"/>	(127) Musculoskeletal illness/impairment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(106) Heart or vascular trouble	<input type="checkbox"/>	<input type="checkbox"/>	(117) Neurological disorders: stroke, epilepsy, seizure, paralysis etc.	<input type="checkbox"/>	<input type="checkbox"/>	(128) Any other illness or injury	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(107) High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	(118) Psychological/psychiatric trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	(129) Admission to hospital	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(108) Kidney stone or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	(119) Misuse of psychoactive substances	<input type="checkbox"/>	<input type="checkbox"/>	(130) Visit to medical practitioner or mental health specialist since last medical examination	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(109) Diabetes, hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>	(120) Attempted suicide or self-harm	<input type="checkbox"/>	<input type="checkbox"/>	(131) Refusal of life insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
(110) Stomach, liver or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	(121) Motion sickness requiring medication	<input type="checkbox"/>	<input type="checkbox"/>	(132) Refusal of aviation licence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(111) Deafness, ear disorder	<input type="checkbox"/>	<input type="checkbox"/>	(122) Anaemia / Sickle cell trait/ other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	(133) Medical rejection from or for military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						(134) Award of pension or compensation for injury or illness	<input type="checkbox"/>	<input type="checkbox"/>			

(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
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