CIVIL AVIATION AUTHORITY

APPLICATION FORM FOR AVIATION MEDICAL CERTIFICATE

Complete this page fully and in block capitals – Refer to instructions for completion

MEDICAL IN CONFIDENCE

(3) Surname:	(4) Previous surname(s):	Title:	(13) UK CAA Reference number: **GBR:**
(5) Forenames:	(6) Date of birth:	(7) Sex	(12) Application Initial ☐ Revalidation ☐ Renewal ☐
(1) State of licence issue:	(2) Medical certificate applied for: 1 ☐ 2 ☐ LAPL ☐		(14) Type of licence applied for:
(8) Place and country of birth:	(9) Nationality:	(15) Occupation (principal)	
(10) Permanent address: **Tel:** **Email:**	(11) Postal address (if different) **Tel:** **Email:**	(16) Employer (17) Last medical examination Date: Place: (18) Aviation licence(s) held (type): Licence number: State of issue:	
(500) GP Name: Address: Telephone Number:		(19) Any Limitations on Licence(s)/Medical Certificate held 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) Flight time total:	(22) Flight time since last medical:	(23) Aircraft Class /Type(s) presently flown:	
(24) Any aviation accident or reported incident since last medical examination? No ☐ Yes ☐ Date: Place: Details:		(25) Type of flying intended: (26) Present flying activity Single pilot ☐ Multi pilot ☐	
(27) Alcohol – state average weekly intake in units:			
(29) Do you smoke tobacco? Never ☐ No ☐ Yes ☐ State type, amount & number of years:		Date stopped:	
(28) Do you currently use any medication? No ☐ Yes ☐ If YES, state medication, dose, date started and why			

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(3) Surname:	(4) Previous surname(s):	Title:	(13) UK CAA Reference number: **GBR:**

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			**Females only:**		
102 Spectacles and/or contact lenses ever worn			113 Head injury or concussion			124 A positive HIV test			150 Gynaecological, menstrual problems		
103 Spectacle/contact lens prescriptions/change since last medical exam			114 Frequent or severe headaches			125 Sexually transmitted disease			151 Are you pregnant?		
104 Hay fever, other allergy			115 Dizziness or fainting spells			126 Admission to hospital			**Family history of:**		
105 Asthma, lung disease			116 Unconsciousness for any reason			127 Any other illness or injury			170 Heart disease		
106 Heart or vascular trouble			117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			128 Visit to medical practitioner since last medical examination			171 High blood pressure		
107 High or low blood pressure			118 Psychological/psychiatric trouble of any sort			129 Sleep Apnoea			172 High cholesterol level		
108 Kidney stone or blood in urine			119 Alcohol/drug/substance abuse			130 Musculoskeletal illness			173 Epilepsy		
109 Diabetes, hormone disorder			120 Attempted suicide			131 Refusal of Life insurance			174 Mental illness		
110 Stomach, liver or intestinal trouble			121 Motion sickness requiring medication			132 Refusal of Flying licence			175 Diabetes		
111 Deafness, ear disorder			122 Anaemia/Sickle cell trait/other blood disorders			133 Medical rejection from or for military service			176 Tuberculosis		
						134 Award of pension or compensation for injury or illness			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 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. 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 the Licensing Authority, 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 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.

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

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

This application form and all attached report forms will be transmitted to the licensing authority. Medical confidentiality shall be respected at all times.

The applicant should personally complete, in full, all questions (sections) on the application form. Writing should be legible and in block capitals, using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any questions, a plain sheet of paper should be used, bearing the applicant's name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the application form for a medical certificate.

Failure to complete the application form in full, or write legibly, may result in non-acceptance of the application form. The making of false or misleading statements or 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. LICENSING AUTHORITY: State name of country this application is to be forwarded to.	**17. LAST APPLICATION FOR A MEDICAL CERTIFICATE:** State date (day, month, year) and place (town, country). Initial applicants state 'NONE'.
2. MEDICAL CERTIFICATE APPLIED FOR: Tick appropriate box. Class 1: Professional Pilot Class 2: Private Pilot LAPL	**18. LICENCE(S) HELD (TYPE):** State type of licence(s) held. Enter licence number and State of issue. 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(S)/MEDICAL CERTIFICATE:** Tick appropriate box and give details of any limitations on your licence(s)/medical certificate eg, 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, SUSPENSION OR REVOCATION:** Tick 'YES' box if you have ever had a medical certificate denied, suspended or revoked, even if only temporary If 'YES', state date (dd/mm/yyyy) and country where occurred.
5. FORENAME(S): State first and middle names (maximum three).	**21. FLIGHT TIME TOTAL:** State total number of hours flown.
6. DATE OF BIRTH: Specify in order dd/mm/yyyy	**22. FLIGHT TIME SINCE LAST MEDICAL:** State number of hours flown since your last medical examination.
7. SEX: Tick as appropriate.	**23. AIRCRAFT CLASS/TYPE (S) PRESENTLY FLOWN:** State name of principal aircraft flown,eg Boeing 737, Cessna 150, etc.
8. PLACE AND COUNTRY OF BIRTH: State town and country of birth.	**24. ANY AIRCRAFT ACCIDENT OR REPORTED INCIDENT SINCE LAST MEDICAL EXAMINATION:** 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 telephone number.	**26. PRESENT FLYING ACTIVITY:** Tick appropriate box to indicate whether you fly as the SOLE pilot or not.
11. POSTAL ADDRESS (IF DIFFERENT): 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 eg, 2 litres of beer.
12. APPLICATION: Tick appropriate box.	**28. DO YOU CURRENTLY USE ANY MEDICATION?:** If 'YES', give full details - name, how much do you take and when, etc. Include any non-prescription medication.
13. REFERENCE NUMBER: State Reference Number allocated to you by the licensing authority Initial applicants enter 'NONE'.	**29. DO YOU SMOKE TOBACCO?** Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (eg, 2 cigars daily; pipe - 1 oz weekly)
14. TYPE OF LICENCE APPLIED FOR: State type of licence applied for from the following list: Aeroplane Transport Pilot Licence Multi-pilot Licence Commercial Pilot Licence/Instrument Rating Commercial Pilot Licence Private Pilot Licence/Instrument Rating Private Pilot Licence Sailplane Pilot Licence Balloon Pilot Licence Light Aircraft Pilot Licence 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 should have the answer 'YES' or 'NO' ticked. You should tick 'YES' if you have ever had the condition in your life and describe the condition and approximate date in the (30) remarks 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 should be answered by female applicants only. If information has been reported on a previous application form for a medical certificate and there has been no change in your condition, you may state 'Previously Reported; No Change Since'. However, you should still tick 'YES' to the condition. Do not report occasional common illnesses such as colds.
15. OCCUPATION: Indicate your principal employment.	
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.