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(1) Surname:	(2) Previous surname(s):	(3) National identification number (if applicable):	
(4) Forename(s):	(5) Date of birth:	(6) Sex	(7) Application
		Male	Initial
		Female	Renewal
(8) Country of license issue:	(9) Class of Medical Assessment applied for:	(10) Type of license applied for	
		(if initial application):	
	1st□2nd □ 3 rd other □		
(11) Place and country of birth:	(12) Nationality:	(13) Occupation (principal):	
(14) Permanent address:	(15) Postal address (if different):	(16) Employer (principal):	
Postcode:		(17) Last medical examination	n
Country:	Postcode:	Date:	
Telephone No.:	Country:	Place:	
Mobile/Cell No.:	Telephone No.:	18) Aviation license(s) held (type):	
		License number(s):	
E-mail:		Country(ies) of issue	
(19) Family physician's name and address:		(20) Any limitations on Licer	nse/MedicalAssessment?
E-mail:	Telephone No.:	No 🗆 Yes 🗖	
Y		Details:	

SI NAA MERTI 24	Company Name			Document No	
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	plication Form for Medi	cal Examination		Issue No	Page No.
ľ	r			1	Page 2 of 8
(21) Have you ever had a authority? If yes, discuss y	an aviation Medical Assessment denied, susper with medical examiner.	nded or revoked by any licensing	(22)	Total flight	(23) Flight time (hours)
No 🗌 Yes 🗌	Date: Place:		Time	e (hours):	since last medical:
					4
Details:			(24)	Aircraft curre	ently flown (e.g.
			Boei	ng 737, Cessn	na C150):
(25) Any aircraft acciden	nt or reported incident since last medical?		(26)	Type of flyin	g intended (1) e.g.
No 🗆 Yes	Date: Plac		Com	mercial air tra	ansport, flying instruction,
		<i>c</i> .	Priva	ate	
Details:					
			(27)	Type of flyin	ng intended (2):
			Sing	le-crew	Multi-crew
(28) Do you drink alcoho	blic beverages?	(30) Do you currently use any me	dication	, including no	on-prescribed
No 🗌 Yes 🗌		medication?			
If YES, state average wee	ekly intake in units:	$Yes \square_{No} \square$			
		If YES, state name of medication,	date con	nmenced, dail	y or weekly dose,
(29) Do you smoke tobac	cco products	and cause (diagnosis):			
Never 🗆					
Previously Date stopp	ped:				
Currently State type	e, amount and number of years				
L					

31) General and medical history: Do you have, or have you ever had, any of the following? YES or NO must be

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ticked after eachquestion. Elaborate YES answers in the remarks section and discuss them with the medical				

examiner.

Yes No Yes No Yes No Yes No

101 Eye disorders/eye surgery	112 Nose or throat disease 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	140 Heart diseases
103 Spectacle/contact lens prescriptions/change since last medical exam	114 Frequent or severe headaches	125 Sexually transmitted disease	141 High blood pressure
104 Hay fever, other allergy	115 Dizziness or fainting spells	126 Admission to hospital	142 High cholesterol levels
105 Asthma, lung disease	116 Unconsciousness for any reason	127 Any other illness or injury	143 Epilepsy
106 Heart or vascular disease	117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.	128 Visit to medical practitioner since last medical examination	144 Mental illness
107 High or low blood pressure	118 Psychological/ psychiatric trouble of any sort	129 Refusal of life insurance	145 Diabetes

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08 Kidney stone or blood in urine	119 Alcohol/drug/substance abuse	130 Refusal of issue or revocation of aviation license		17 Allergy/asthma/eczema 18 Inherited disorders
09 Diabetes, hormone disorder	120 Attempted suicides	131 Medical rejection from or for military service		19 Glaucoma
10 Stomach, liver or intestinal trou	ble 121 Motion sickness requiring medication	132 Award of pension or compensation for injury or illness		
	OVER AND			

<form> Characterior: Recarction: Characterior: Recarction: Construction: Characterior: Construction: Construction: Construction:</form>	Company Real	ny Name		Document N	0
Dummer Till Insue No Page 5 of 8 Yes No Yes No Yes No Yes No Deafness, ear disease 122 Anaemia/Sickle cell 150 Gynaecological disorders Including menstrual) 151 Are you pregnant? 2) Remarks: If previously reported and unchanged, so state.				ECAA/PEL/OF/030	
Application Form for Medical Examination 1 Page 5 of 8 Yes No Yes No Yes No Yes No Deafness, ear disease 122 Anaemia/Sickle cell 150 Gynaccological disorders Irait/other blood disorders 11 190 Gynaccological disorders (ncluding menstrual) 11 191 For you pregnant? 2) Remarks: If previously reported and unchanged, so state. 191 How pregnant? (32) Declaration: I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complet oriexet. I further declare that I have not withhed any relevant information or made any misleading statement is. I understand that if I have made any fa misleading statement is. I understand that if I have made any fa misleading statement is consection with this application. or if I do not consect to release the supporting medical information, the Authority may refuse to gra a Medical Assessment granted, without prejudice to any other legal action applicable pursuant to <i>ECARIS Part 2.11</i> . CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby give my consent that all relevant medical information may be released and submit the Medical Assessment granted, without prejudice to any other legal action applicable pursuant to <i>ECARIS Part 2.11</i> .					
Application Form for Medical Examination 1 Page 5 of 8 Yes No Yes No Yes No Yes No Deafness, ear disease 122 Anaemia/Sickle cell 150 Gynaccological disorders Irait/other blood disorders 111 151 Are you pregnant? 2) Remarks: If previously reported and unchanged, so state. 151 Are you pregnant? (32) Declaration: I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete orecret. I further declare that I have not withhed any relevant information or made any misleading statement is concellow with disapplication, or II do not consent to release the supporting medical information, the Authority may refuse to grave a Medical Assessment granted, without prejudice to any other legal action applicable pursuant to <i>ECARAS Part 2.11</i> . CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby give my consent that all relevant medical information may be released and submit the Medical Assessment disease of the Licensing Authority. Note: Medical confidentiality will be respected at all times.	Document Title			Issue No	Page No.
Deafness, ear disease 122 Anaemia/Sickle celt 150 Gynaecological disorders (including menstrual) 151 Are you pregnant? 2) Remarks: If previously reported and unchanged, so state. (32) Declaration: I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made above and that to the best of my belief they are complete correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any fall misleading statement in connection with this application, or iI 1 do not consent to release the supporting medical information, the Authority may refuse to grat a Medical Assessment or may withdraw any Medical Assessment granted, without prejudice to any other legal action applicable pursuant to ECARAS Part 2.11. CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby give my consent that all relevant medical information may be released and submitt the Medical Assessor of the Licensing Authority. Note: Medical confidentiality will be respected at all times.		ation Form for Medical I	Examination		-
Contents of an oblight of the blood disorders Image: I	Yes No	Yes No	Yes No	Yes	s No
Contents, and docked Image: Image					
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CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby give my consent that all relevant medical information may be released and submitted the Medical Assessor of the Licensing Authority. Note: Medical confidentiality will be respected at all times.					
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the Medical Assessor of the Licensing Authority. Note: Medical confidentiality will be respected at all times.					
Date Signature of applicant Signature of medical examiner (Witness)	CONSENT TO RELEA the Medical Assessor of	ASE OF MEDICAL INFORMATION: I he the Licensing Authority. Note: Medical confid	reby give my consent that all rele dentiality will be respected at all t	vant medical inform imes.	ation may be released and submitt
Date Signature of applicant Signature of medical examiner (Witness)					
	Date	Signature of applicant			examiner (Witness)
		Signature of appreada		Signature of medica	



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

This Application Form, all attached Report Forms and Reports are required in accordance with ICAO Annex 1 and will be transmitted to the Medical Assessor of the Licensing Authority. Medical confidentiality will be respected at all times.

The **Applicant must personally** complete in full all questions (boxes) on the Application Form. Writing must be in **Block letters** with a black **ballpoint pen** and must be **legible**. Exert sufficient pressure to make legible copies. If more space is required to answer any question, use a plain sheet of paper with the additional information, your signature and the date. 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 the application form not being accepted. The making of False or Misleading statements or the Withholding of relevant information in respect of this application may result in criminal prosecution, refusal of this application and/or withdrawal of any Medical Assessment(s) previously granted.

1. SURNAME: State surname/family name.	12. NATIONALITY: State name of country of citizenship.
PREVIOUS SURNAME(S): If your surname or family name has been changed for any reason, state previous name(s).	13. OCCUPATION (principal): State principal occupation
1. NATIONAL IDENTIFICATION NUMBER (if applicable): State your national identification number or social security number allocated to you by your country of citizenship.	14. PERMANENT ADDRESS: State main place of residence, with contact details, telephone number(s) and e-mail address.
4. FORENAMES: State first and middle names (maximum three).	15. POSTAL ADDRESS(if different from Permanent Address):If relevant, state postal address and telephone number.
5. DATE OF BIRTH: Specify in order: day (DD), month (MM), year (YYYY) innumerals, e.g. 22-08-1960.	16. EMPLOYER (principal): State principal employer
6. SEX: Tick appropriate box.	17. LAST MEDICAL EXAMINATION: State date (day/month/year) and place (city/town and country)of last aviation medical examination. Initial applicants state "NONE
7. APPLICATION: Tick appropriate box. Tick "Initial" if this is your first application to this licensing authority, even if you hold other similar licences issued by another licensing authority.	 AVIATION LICENCE(S) HELD (TYPE). LICENCE NUMBER(S), COUNTRY(IES) OF ISSUE: Provide information concerning licenses already held
 COUNTRY OF LICENCE ISSUE: State issuing country of primary licence (if not initial application). CLASS OF MEDICAL CERTIFICATE APPLIED 	 19. FAMILY PHYSICIAN'S NAME AND ADDRESS (if applicable) Provide contact details of family physician. 20. ANY LIMITATIONS ON THE
9. CLASS OF MEDICAL CERTIFICATE APPLIED FOR: Tick appropriate box.	20. ANY LIMITATIONS ON THE LICENCE/MEDICAL ASSESSMENT: Tick appropriate box and provide details of any limitations on your license(s) and/or medical certificate(s), e.g. correctinglenses, valid day-time only, multi-pilot operations only.

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10. TYPE OF LICENCE APPLIED FOR Application Form for Medical Exa (if initial application):	21. HAVE YOU EVER HAD AN AVIATIONMEDICAL
If applying for the first issuance of a licence to this	REVOKEDBY ANY LICENSING AUTHORITY? IF
licensingauthority, please state type of licence applied	YES, DISCUSSWITH THE MEDICAL EXAMINER:
for.	Tick "Yes" if you have ever had a Medical Assessment
	denied, suspended or revoked, even if temporarily.
	Provide the date, place and details, and discuss with the
	medical examiner.
11. PLACE AND COUNTRY OF BIRTH:	22. TOTAL FLIGHT TIME (HOURS):
State city/town and country of birth.	For pilots, state total number of hours flown in an
	operating capacity. Non-pilots state "Not applicable".
	sporutingeupuerty. Tion priots state Tiot upprousie :
23. FLIGHT TIME (HOURS) SINCE LAST MEDICAL	28. IF YOU DRINK ALCOHOLIC BEVERAGES STATE
EXAMINATON:	AVERAGE WEEKLY INTAKE IN UNITS
State number of hours flown in an operating capacity	State weekly intake e.g. 12 units (beer and wine)
since last aviation medical examination.	Note: 1 unit ~ 12 g alcohol; this corresponds to the amount
	of alcohol in a standard (0.34L) can or bottle of beer, a
	glass of wine, etc.
24. AIRCRAFT CURRENTLY FLOWN:	29. DO YOU SMOKE TOBACCO PRODUCTS?
State the name of aircraft currently flown e.g.	Tick applicable box. Current smokers should state type and
Boeing 737,	amount e.g. 20 cigarettes per day; pipe, 30 grams
Airbus A 330, Cessna 150.	weekly.
25. ANY AIRCRAFT ACCIDENT OR REPORTED	30. DO YOU CURRENTLY USE ANY MEDICATION
INCIDENT SINCE LAST MEDICAL	INCLUDING NON-PRESCRIBED MEDICATION?
EXAMINATION?	State medications prescribed by a medical practioner
If "Yes" provide details.	and also
II Tes provide details.	
	non-prescribed medication e.g. herbal remedies, medications
	bought without prescription ("over the counter"). If "Yes" is
	ticked, provide details: name of medication, date treatment was
	commenced, daily/weekly dose and the condition or
AC TYPE OF ELVING INTENDED (1).	problem for which the medication is taken.
26. TYPE OF FLYING INTENDED (1):	31. GENERAL AND MEDICAL HISTORY:
Provide details of intended flying e.g. commercial	All items under this heading from number 101 to 149
air transport	inclusive
flying instruction, private.	(101 to 151 for females) 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
▼Y	date in
Y	the REMARKS box. All questions asked are medically
	important even though this may not be readily apparent.
	Items numbered 140 to 149 relate to immediate family
	history.
	Items numbered 150 to 151 should be completed only by
	female applicants.
	If information has been reported on a previous
	application form



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	applied for and there has been no change in your
	condition, you
	may state 'Previously Reported, Unchanged'. However,
	you
	must still tick YES' to the condition. Do not report
	occasional
	common self-limiting illnesses such as colds.
	CR I
27. TYPE OF FLYING INTENDED (2):	32. DECLARATION AND CONSENT TO RELEASE OF
Tick appropriate box (es).	MEDICAL INFORMATION:
	Do not sign or date this section until indicated to do so by
	the
	Medical examiner who will act as witness and sign
	accordingly.

AN APPLICANT HAS THE RIGHT TO REFUSE ANY EXAMINTION AND TEST AND TO REQUEST REFERRAL TO THEAUTHORITY HOWEVER; THIS MAY ENTAIL TEMPORARY DENIAL OF MEDICAL CERTIFICATION.