CIVIL AVIATION SAFETY AND SECURITY OVERSIGHT AGENCY

FORM

O-PEL017
June 2017

APPLICATION FORM FOR AN AVIATION MEDICAL ASSESSMENT

Complete this page fully using a black ballpoint pen and in block letters – see instruction page for details. MEDICAL IN CONFIDENCE

<table>
<tr><td>(1) Surname:</td><td>(2) Middle name</td><td colspan="2">(3) National identification number or passport (if applicable):</td></tr>
<tr><td>(4) First name</td><td>(5) Date of birth: (dd/mm/yyyy)</td><td>(6) Sex
Male □
Female □</td><td>(7) Application
Initial □
Renewal □</td></tr>
<tr><td>(8) Country of licence issue:</td><td colspan="2">(9) Class of Medical Assessment applied for:
□ 1st Class □ 2nd Class □ 3rd Class</td><td>(10) Type of licence applied for (if initial application):</td></tr>
<tr><td>(11) Place and country of birth:</td><td>(12) Nationality:</td><td colspan="2">(13) Main Occupation</td></tr>
<tr><td rowspan="2">(14) Permanent address:

Postcode:

Country:

Telephone No.:

Mobile/Cell No.:

Email:</td><td rowspan="2">(15) Postal address (if different)

Postcode:

Country:

Telephone No.:</td><td colspan="2">(16) Current Employer</td></tr>
<tr><td colspan="2">(17) Last medical examination
Date:

Place:

(18) Aviation licence(s) held (type):
Licence number(s):</td></tr>
</table>

		Country(ies) of issue:
(19) Family/Personal physician's name and address Email: Telephone		(20) Any limitations on Licence/Medical Assessment? No □ Yes □ Details:
(21) Have you ever had an aviation Medical Assessment denied, suspended or revoked by any licensing authority? If yes, discuss with medical examiner. No □ Yes □ Date: Place: Details		(22) Total flight time (hours): (24) Aircraft currently flown (e.g. Boeing 737, Cessna C150):
		(23) Flight time (hours) since last medical:
(25) Any aircraft accident or reported incident since last medical? No □ Yes □ Date: Place: Details:		(26) Type of flying intended (1) e.g. commercial air transport, flying instruction, private: (27) Do you intend to fly? Single Crew □ Multi Crew □
(28) Do you drink alcoholic beverages? No □ Yes □ If YES, state average weekly intake in units:	(30) Do you currently use any medication, including non-prescribed medication? Yes □ No □ If YES, state name of medication, date commenced, daily or weekly dose, and cause (diagnosis)	
(29) Do you smoke tobacco products? Never		

Previously Date stopped: State type, amount and number of Currently years:	

(31) General and medical history: Do you have, or have you ever had, any of the following: YES (Y) or NO (N) must be ticked after each question. Elaborate YES answers in the remarks section and discuss them with the medical examiner.

	Y	N		Y	N		Y	N		Y	N
32 Eye disorders /eye surgery			43 Nose or throat disease or speech disorder			54 Malaria or other tropical disease			65 High blood pressure		
33 Spectacles and/or contact lenses ever worn			44 Head injury or concussion			55 A positive HIV test			66 High cholesterol level		
34 Spectacles/ contacts lens prescriptions/ change since last medical exam			45 Frequent or severe headaches			56 Sexually transmitted disease			67 Epilepsy		
35 Hay fever, other allergy			46 Dizziness or fainting spells			57 Admission to hospital			68 Mental Illness		
36 Asthma, lung cancer			47 Un-consciousness for any reason			58 Any other illness or injury			69 Diabetes		
37 Heart or vascular disease			48 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			59 Visit to medical practitioner since last medical examination			70 Tuberculosis		
38High or low blood pressure			49 Psychological/ psychiatric trouble of any sort			60 Refusal of life insurance			71 Allergy /asthma/eczema		
39 Kidney stone or blood in urine			50 Alcohol/drug/ substance abuse			61 Refusal of issue or revocation of aviation licence			72 Inherited disorders		
40 Diabetes, hormone disorder			51 Attempted suicide			62 Medical rejection from or for military service			73 Glaucoma		
41 Stomach, liver or intestinal trouble			52 Motion sickness requiring medication			63 Award of pension or compensation for injury or illness			**FEMALES ONLY:** 74 Gynaecological disorders		

									(including menstrual)			
42 Deafness, ear disease			53 Anaemia/ Sickle cell trait/other blood disorders			**Family History of:** 64 Heart disease			75 Are you pregnant?			

(76) Remarks: If previously reported and unchanged, so state.

(77) In the course of exercising the privileges of the license you have applied for; do you accept the following basic laboratory investigations;

Complete Blood Count, Haemoglobin electrophoresis (initial visit), Pregnancy tests for all females, Random blood sugar, Hb A1C for all diabetics on acceptable therapy, HIV? YES/NO
(You must write "YES OR NO")

(78) 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 and 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 false or misleading statements in connection with this application, or if I do not consent to release the supporting medical information, the Authority may refuse to grant me a Medical Assessment or may withdraw any Medical Assessment granted, without prejudice to any other legal action.

CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby give my consent that all relevant medical information may be released and submitted to the Medical Assessor of the Licensing Authority. Medical confidentiality will be respected at all times.

Signature of applicant

……

Signature of medical examiner/ Witness

……..

Date

……..

REPORT OF THE MEDICAL EXAMINATION

(1) Examination Category Initial □ Renewal □ Other □	(2) Height (cm)	(3) Weight (kg)	(4) Body Mass Index (BMI) Waist Circumference (cm)	(5) Eye Colour	(6) Hair Colour	(7) Blood Pressure-seated (mm Hg) Rate (bpm)	(8) Pulse - resting Rhythm Reg. □ Irreg. □

Clinical Examination: Check each Item – Normal (N); Abnormal (Ab)

	N	AB		N	AB
(9) Head, face, neck, scalp			(20) Anus, rectum (indicate if not examined)		
(10) Mouth, throat, teeth			(21) Genito-urinary system (indicate if not examined)		
11) Nose, sinuses			(22) Endocrine System		
(12) Ears, especially eardrum appearance and motility			(23) Upper and lower limbs, joints		
(13) Eyes – orbit and adnexa; visual fields			(24) Spine, other musculoskeletal		
(14) Eyes – pupils and optic fundi			(25) Neurologic – reflexes, etc.		
(15) Eyes – ocular motility; nystagmus, eye muscle balance			(26) Psychiatric		
(16) Lungs, chest, breasts (indicate if breasts not examined			(27) Skin and lymphatics		
(17) Heart			(28) General systemic		
(18) Vascular system			(29) **Notes:** Describe every abnormal finding. Enter applicable item number before each comment		
(19) Abdomen, hernia, liver, spleen					

Visual Acuity

(30) Distant vision at 6m	Glasses	Contact Lenses

	Uncorrected	Corrected to	Not Needed
Right Eye			
Left Eye			
Both Eyes			

(31) Intermediate vision N14 at 100 cm	**Uncorrected to**	**Corrected to**	(33) Spectacles	(34) Contact Glasses
Right Eye			Yes No.	Yes No.
Left Eye			Type	Type
Both Eyes				

(32) Near Vision N5 at 30 – 45 cm	**Uncorrected to**	**Corrected to**	(35) Colour perception	Normal □ Abnormal □
Right Eye			Pseudo-isochromatic plates	Type:
Left Eye			No. of plates:	No. of errors:
Both Eyes				

(36) Measure of heterophoria Maddox Rod or Maddox Wing	Esophoria	Esophoria	Hyperphoria

(37) CVD Risk Factor Assessment					
ITEM					
Item	**Y**	**N**	**Item**	**Y**	**N**
(+) Family history			Obesity		
Age and gender			Hypertension		
Smoking			High cholesterol		
Exercise			Diabetes		
COMMENTS					

(38) Hearing When (39) not performed	Right ear	Left ear
Conversational voice test at 2m back turned to examiner	Normal □ Abnormal □	Normal □ Abnormal □

(39) Audiometric Screening				
Hz	500	1000	2000	3000
Right				
Left				

(40) Special Investigations

	Date performed	Result	Next due
1. Resting ECG			
2. Stress-ECG (When Required)			
3. Lung function test (When Required)			
4. Lipogram (When Required)			
5. Chest X-ray			

(41) Urinalysis	Normal □		Abnormal □	
Glucose	Protein	Blood	Other	

(42) Mental or Behavioural health aspects of fitness discussed.

Yes No

(43) Physical aspects of fitness discussed.

Yes No

(44) Preventive health advice given.

Yes No

(45) Medical examiner's recommendations

Name of applicant:	Date of birth:
□ Fit class: _____	□ Medical certificate issued by undersigned (copy attached)
□ Unfit class _____ State reasons:	
□ Deferred for further evaluation. If yes, why and to whom?	

(46) Comments, restrictions and Limitations

(47) Medical Examiner's declaration:

I hereby certify that i/my DME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

(48) Place and date:	Examiner's Name and Address	Examiner's Stamp
Medical Examiner's signature:	Email and Phone no:	