APPLICATION FOR MEDICAL CERTIFICATE

INSTRUCTIONS
Print or type. Do not write in shaded areas. These are for CAAP use only. Submit original only to the CAAP or a CAAP Authorized Person. If additional space is required, use an attachment

A. APPLICATION IS HEREBY MADE FOR ISSUANCE OF THE FOLLOWING AVIATION MEDICAL CERTIFICATE:

1. ☐ CLASS 1 2. ☐ CLASS 2 3. ☐ CLASS 3

B. AIRMAN PERSONAL INFORMATION:

1. NAME (*Last* ---------------------- *First*------------------------- *Middle)*	5. PERMANENT ADDRESS (Street or PO Box Number)				
2. TELEPHONE:					
3. FAX NUMBER:					
4. EMAIL ADDRESS:	6. CITY	ISLAND/STATE/PROVINCE	MAIL CODE	COUNTRY	

7. HEIGHT	8. WEIGHT	9. HAIR	10. EYES	11. SEX	12. DATE OF BIRTH / / DAY MONTH YEAR	13. **FOR CAAP USE**

C. PEL LICENSE AND MEDICAL INFORMATION:

1. -PEL LICENSE #	2. TOTAL FLT HRS	3. TOTAL LAST 6 MONTHS	4. AVIATION EMPLOYER

5. DATE LAST MEDICAL / / DAY MONTH YEAR	6. HAS YOUR AVIATION MEDICAL CERTIFICATE EVER BEEN DENIED, SUSPENDED OR REVOKED? (a) ☐ **YES (PROVIDE EXPLANATION)** (b) ☐ **NO** If yes, give date: / / DAY MONTH YEAR	8. **FOR CAAP USE**
7. EXPLANATION FOR DENIAL SUSPENSION OR REVOCATION	:	

D. MEDICAL HISTORY:

HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? *Answer "Yes" or "No" for every condition listed below. In the EXPLANATIONS box below, you may note "**PREVIOUSLY REPORTED, NO CHANGE**" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition.* (**See instructions for completion**):

	YES	NO	CONDITION:		YES	NO	CONDITION:
1.	☐	☐	Frequent or severe headaches?	13.	☐	☐	Neurological disorders, epilepsy, seizures, stroke, paralysis, etc
2.	☐	☐	Dizziness or fainting spell?	14.	☐	☐	Mental disorders of any sort, depression, anxiety, etc
3.	☐	☐	Unconsciousness for any reason?	15.	☐	☐	Motion sickness requiring medication?
4.	☐	☐	Eye or vision trouble except for glasses?	16.	☐	☐	Medical discharge from any organization?
5.	☐	☐	Hay fever or allergy?	17.	☐	☐	Medical rejection by any organization?
6.	☐	☐	Asthma or lung disease?	18.	☐	☐	Rejection for life or medical insurance?
7.	☐	☐	Heart or vascular trouble or HIV?	19.	☐	☐	Admission to hospital?
8.	☐	☐	High or low blood pressure?	20.	☐	☐	Alcohol dependence or abuse?
9.	☐	☐	Stomach, liver, or intestinal trouble?	21.	☐	☐	Substance dependence, or substance abuse, or use of illegal substances in the last 2 years, or failed a drug test ever?
10.	☐	☐	Kidney stone or blood in the urine?	22.	☐	☐	Other illness disability or surgery? (*attach report*)
11.	☐	☐	Suicide attempt?	23.	☐	☐	Near vision contact lenses?
12.	☐	☐	Diabetes or sugar in urine				

24. **EXPLANATIONS**:	25. **FOR CAAP USE**

E. VISITS TO THE HEALTH PROFESSIONAL WITHIN LAST 3 YEARS? **(a)** ☐ **YES** (*Explain Below*) (b) ☐ **NO**

Date	***Name, Address & Type of Health Professional Consulted***	***Reason***

F. USE OF MEDICATION? (*Daily or Regular Use: Non-Prescription or Prescription*) **(a)** ☐ **YES** (*List Below*) (b) ☐ **NO**

G. CONVICTION AND/OR ADMINISTRATIVE HISTORY:

1. ☐ **YES** (a) ☐ **NO** **(b)**	History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in denial, suspension, cancellation or revocation of driving privileges or which resulted in attendance at an educational or rehabilitation program?	2. ☐ **YES** **(a)** ☐ **NO** **(b)**	History of nontraffic conviction(s)? (misdemeanors or felonies)
			3. **FOR CAAP USE**

H. CERTIFICATION – ***I hereby represent that the information entered in this application is true and correct.***

A person shall not with intent to deceive: or make any false representation for the purpose of procuring for himself or any other person the grant, issue, renewal or variation of any such certificate...	1. DATE	2. APPLICANT SIGNATURE :

REPORT OF MEDICAL EXAMINATION

I. GENERAL EXAMINATION:

1. Height *(inches)*	2. Weight *(pounds)*	3. Statement of Demonstrated Ability (a) ☐ YES (b) ☐ NO DEFECT NOTED?

	Normal	Abnormal	CONDITION:		Normal	Abnormal	CONDITION:
4.	☐	☐	Head, face, neck and scalp?	16	☐	☐	Vascular system (Pulse, amplitude & character, arms, legs, other
5.	☐	☐	Nose?	17	☐	☐	Abdomen and viscera (including hernia)
6.	☐	☐	Sinuses?	18.	☐	☐	Anus (not including digital examination)
7.	☐	☐	Mouth and throat?	19.	☐	☐	Skin
8.	☐	☐	Ears (General)	20.	☐	☐	G.U. system (not including pelvic examination)
9.	☐	☐	Ear Drums (perforation)	21.	☐	☐	Upper and lower extremities (strength and range of motion)
10.	☐	☐	Eyes (General)	22.	☐	☐	Spine, other musculoskeletal
11	☐	☐	Ophthalmoscopic	23.	☐	☐	Identifying body marks, scars, tattoos (size and location)
12.	☐	☐	Pupils (Equality and Reaction)	24.	☐	☐	Lymphatics
13.	☐	☐	Ocular motility (associated parallel movement,	25.	☐	☐	Neurologic (tendon reflexes, equilibrium, cranial nerves, coordination, etc.)
14.	☐	☐	Lungs and Chest (not including breast exam)	26.	☐	☐	Psychiatric (appearance, behavior, mood, communication & memory)
15.	☐	☐	Heart (precordial activity, rhythm, sounds & murmurs)	27.	☐	☐	General Systemic

28. NOTES: (Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

J. HEARING:

1. Conversational Voice Test (at 6 feet)	2. Record Audiometric Speech Discrimination score below		3. Right Ear					4. Left Ear				
(a) ☐ Pass		Audiometer	500	1000	2000	3000	4000	500	1000	2000	3000	4000
(b) ☐ Fail		Threshold in decibels	(a)	(b)	(c)	(d)	(e)	(a)	(b)	(c)	(d)	(e)

K. VISION:

1. Distant Vision	2. Near Vision	3. Intermediate Vision	4. Color Vision	5. Visual Acuity
a. Right= 20/ Corr. to 20/	a. Right= 20/ Corr. to 20/	a. Right= 20/ Corr. to 20/	Test Used __________	
b. Left= 20/ Corr. to 20/	b. Left= 20/ Corr. to 20/	b. Left= 20/ Corr. to 20/	(a) ☐ Pass	
c. Both= 20/ Corr. to 20/	c. Both= 20/ Corr. to 20/	c. Both= 20/ Corr. to 20/	(b) ☐ Fail	

L. HETEROPHORIA (in prism diopters):	**ESO**	**EXO**	**R.H**	**L.H**

M. CARDIOVASCULAR:

1. Blood Pressure (a) Systolic: (b) Diastolic: 2. Pulse (Sitting): 3. ECG (Date):

N. URINALYSIS:

1. ☐ Normal 2. ☐ Abnormal 3. Albumin (SPECIFY)➔ 4. Sugar (SPECIFY)➔

O. DRUG SCREENING (Commercial and Airline Transport Pilots):

1. Methamphetamine a. ☐ NEGATIVE b. ☐ POSITIVE 2. Cannabinoids a. ☐ NEGATIVE b. ☐ POSITIVE

P. COMMENTS ON HISTORY AND FINDINGS: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.

1. Significant Medical History? (a) ☐ YES (b) ☐ NO 2. Abnormal Physical Findings? (a) ☐ YES (b) ☐ NO

Q. MEDICAL EXAMINER'S ANALYSIS AND DECLARATION:

1. ☐ ISSUANCE RECOMMENDED 2. ☐ ISSUANCE NOT RECOMMENDED

3. DISQUALIFYING DEFECTS: (List by section letter and item number or enter the word "None")

4. ***I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachments embodies my findings completely and correctly***:

5. Date of Examination / / DAY MONTH YEAR	6. AME SERIAL NUMBER	8. AME PRINTED NAME	10. FOR CAAP USE:
	7. AME TELEPHONE #	9. AME SIGNATURE	