APPLICATION FOR

MEDICAL CERTIFICATE

Control No._____

INSTRUCTIONS

Print or type. Do not write in shaded areas. These are for CAAP use.
Submit original only to CAAP or a CAAP Authorized Person.
If additional space id 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 NUMBER:							
3. FAX NUMBER:							
4. EMAIL ADDRESS:				6. CITY ISLAND/STATE/PROVINCE MAIL COUNTRY			
7. HEIGHT(m)	8. WEIGHT (kg)	9. HAIR	10. EYES	11. SEX	12. DATE OF BIRTH / / DAY MONTH YEAR	13. AGE	**14. FOR CAAP USE**

C. PEL LICENSE AND MEDICAL INFORMATION:

1. PEL LICENSE #	2. TOTAL FLIGHT HOURS	3. TOTAL LAST 6 MONTHS	4. AVIATION EMPLOYER
5. DATE LAST MEDICAL / / DAY MONTH YEAR	6. HAS YOUR AVIATION MEDICAL CERTIFICATE EVER BEEN DENEID, 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* ***EXPLANATION*** *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 instruction 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 disorder 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?				
11.	☐	☐	Suicide attempt?	22.	☐	☐	Other illness/disability or surgery? (attach report)
12.	☐	☐	Diabetes or sugar in urine?	23.	☐	☐	Near vision contact lenses?

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

E. VISITS TO HEALTH PROFESSIONAL WITHIN LAST 5 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 priviledge 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 *(m)*	2. Weight *(kg)*	3. Body Mass Index	4. Statement of Demonstrated Ability (a) ☐ YES (b) ☐ NO DEFECT NOTED?

Normal	Abnormal	CONDITION:	Normal	Abnormal	CONDITION:
5. ☐	☐	Head, face, neck and scalp	17. ☐	☐	Vascular System (pulse, amplitude, & character, arms, legs and other)
6. ☐	☐	Nose	18. ☐	☐	Abdomen and viscera (including hernia)
7. ☐	☐	Sinuses	19. ☐	☐	Anus (not including digital examination)
8. ☐	☐	Mouth and Throat	20. ☐	☐	Skin
9. ☐	☐	Ears (general)	21. ☐	☐	G.U. System (not including pelvic examination)
10. ☐	☐	Ear Drums (perforation)	22. ☐	☐	Upper and lower extremities (strength and range of motion)
11. ☐	☐	Eyes (general)	23. ☐	☐	Spine, other musculoskeletal
12. ☐	☐	Ophthalmoscopic	24. ☐	☐	Identifying body marks, scars, tattoos (size and location)
13. ☐	☐	Pupils (equality and reaction)	25. ☐	☐	Lymphatics
14. ☐	☐	Ocular motility (associated parallel movement)	26. ☐	☐	Neurologic (tendon reflexes, equilibrium, cranial nerves, etc.)
15. ☐	☐	Lungs and Chest (not including breast exam)	27. ☐	☐	Psychiatric (appearance, behavior, mood, communication & memory)
16. ☐	☐	Heart (precordial activity rhythm, sounds & murmurs)	28. ☐	☐	General Systemic

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

K. VISION:

1. Distant Vision	2. Near Vision	3. Intermediate Vision	4. Color Vision	5. Visual Field
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): 4. Chest Radiograph (date):

N. URINALYSIS:

1. ☐ Normal 2. ☐ Abnormal 3. Albumin (specify) _____ 4. Sugar (specify) _____

O. DRUG SCREENING:

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

P. COMMENTS ON HISTORY AND FINDINGS: AME shall comment **"YES"** answer in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECG's, 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. DISQUALIFICATION 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 NUMBER	9. AME SIGNATURE	