Republic of the Philippines
Civil Aviation Authority of the Philippines

APPLICATION FOR AVIATION MEDICAL CERTIFICATE

INSTRUCTIONS: Print or type in blue or black ink. Submit original only to Aeromedical Staff.
When downloading the form, use legal size paper (8.5x14 inches) and should be printed double-sided (back-to-back).
Do not leave any blanks, write N/A if not applicable. If additional space is required, use an attachment. **CONTROL NO.**: _____

A. APPLICATION IS HEREBY MADE FOR ISSUANCE OF THE FOLLOWING AVIATION MEDICAL CERTIFICATE: 1. ☐ CLASS 1 2. ☐ CLASS 2 3. ☐ CLASS 3 | **LICENSE HELD:**

B. AIRMAN PERSONAL INFORMATION:

1. NAME (LAST----------FIRST----------MIDDLE)	4. PERMANENT ADDRESS (House No., Street, City, Province, Country, Zip Code)
2. CONTACT NUMBER:	
3. EMAIL ADDRESS:	

5. DATE OF BIRTH / / DAY MONTH YEAR	6. Age	7. Sex	8. Citizenship	9. Hair Color	10. Eye Color

C. PEL LICENSE AND MEDICAL INFORMATION:

1. PEL LICENSE #	2. TOTAL FLIGHT HOURS	3. TOTAL LAST 6 MONTHS	4. AVIATION EMPLOYER/SCHOOL

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

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, indicate what and when were you diagnosed and management or treatment if any.*

YES	NO	CONDITION:	YES	NO	CONDITION:
1. ☐	☐	Frequent or severe headaches?	13. ☐	☐	Neurologic disorders, epilepsy, seizures, stroke, paralysis, etc.
2. ☐	☐	Dizziness or fainting spell?	14. ☐	☐	Mental condition 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 from 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, substance abuse, or use of illegal substance 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:

E. VISITS TO 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 privilege or which resulted in attendance at an educational or rehabilitation program?	2. ☐ YES (a) ☐ NO (b)	History of nontraffic conviction(s)? (misdemeanors or felonies)

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

1. *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.*
2. *In compliance with the Data Privacy Act of 2012 and to ensure a safe and transparent usage of your personal information, the data you will submit will be used for the purpose of aeromedical application and assessment. Your personal information or data will be retained and dispose according to the existing laws and regulations of the National Archives of the Philippines. By signing below you agreed, understood and gave your consent.*

_____ **APPLICANT'S SIGNATURE OVER PRINTED NAME**

_____ **DATE**

REPORT OF MEDICAL EXAMINATION

I. GENERAL EXAMINATION:

1. Height *(m)*	2. Weight *(kg)*	3. Body Mass Index	4. Statement of Demonstrated Ability
			(a) ☐ YES DEFECT NOTED _____ (b) ☐

Normal	Abnormal Condition:	Normal	Abnormal Condition:
5. ☐	☐ Head, face, neck and scalp	17. ☐	☐ Vascular System (pulse, amplitude, & character, arms, legs 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 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 nerve, etc.)
15. ☐	☐ Lungs and Chest (not including breast exam)	27. ☐	☐ Psychiatric (appearance, behavior, mood, communication & memory)
16. ☐	☐ Heart (precordial activity rhythm, sounds and 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) ☐ Passed	
c. Both= 20/_____ Corr. to 20/_____	c. Both= 20/_____ Corr. to 20/_____	c. Both= 20/_____ Corr. to 20/_____	(b) ☐ Failed	

L. CARDIOVASCULAR:

1. Blood Pressure (a) Systolic: (b) Diastolic 2. Pulse (Sitting) 3. ECG 4. Chest Radiograph:

M. URINALYSIS:

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

N. DRUG SCREENING:

1. Methamphetamine a. ☐ NEGATIVE b. ☐ POSITIVE

2. Cannabinoids a. ☐ NEGATIVE b. ☐ POSITIVE

O. COMMENTS ON HISTORY AND FINDINGS: AME shall comment "**YES**" answer in the Medical History section and abnormal findings of the examination. (Attach all consultation reports, ECG's, X-rays and other test requested or given to this report before submission.)

1. Significant Medical History? (a) ☐ YES (b) ☐ NO

2. Abnormal Physical Findings? (a) ☐ YES (b) ☐ NO

P. 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	