APPLICATION FOR
MEDICAL CERTIFICATE

INSTRUCTIONS
Print or type. Do not write in shaded areas. These are for CAAV use only. Submit original only to the CAAV Aviation Medical Assessor or a CAAV-FSSD PEL Division. If additional space is required, use an attachment

A. SỐ GIẤY PHÉP/ APPLICANT'S CAAV PEL NUMBER	B. CLASS OF MEDICAL CERTIFICATED APPLIED FOR:
	a. ☐ CLASS 1 b. ☐ CLASS 2 c. ☐ CLASS 3

C. AIRMAN PERSONAL INFORMATION:

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

6. HAIR COLOR	7. EYE COLOR	8. SEX	9. DATE OF BIRTH	10. CITIZENSHIP *(Nationality)*
			DD / MM / YYYY	

D. PEL LICENSE & MEDICAL INFORMATION:

1. ☐ Student Pilot 3. ☐ Commercial Pilot 5. ☐ Flight Engineer 7. ☐ Sport/Recreation 9. ☐ Air Traffic Controller
2. ☐ Private Pilot 4. ☐ Airline Transport Pilot 6. ☐ Flight Instructor 8. ☐ Cabin Crew Member 10. ☐ Other:

11. TOTAL FLT HRS	12. LAST 6 MONTHS?	13. DATE LAST MEDICAL	14. HAS YOUR AVIATION MEDICAL CERTIFICATE EVER BEEN DENIED, SUSPENDED OR REVOKED? ☐ **YES** ☐ **NO** If yes, give date:
		DD / MM / YYYY	DD / MM / YYYYR

E. CURRENT USE OF MEDICATION? *(Prescription or Non Prescription)* **NO** **YES** (*List with dosage below)*

F. 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?	12.	☐	☐	Neurological disorders, epilepsy, seizures, stroke, paralysis, etc
2.	☐	☐	Dizziness or fainting spell?	13	☐	☐	Mental disorders of any sort, depression, anxiety, etc
3.	☐	☐	Unconsciousness for any reason?	14.	☐	☐	Substance dependence, or substance abuse, or use of illegal substances in the last 2 years, or failed a drug test ever?
4.	☐	☐	Eye or vision trouble except for glasses?	15.	☐	☐	Alcohol dependence or abuse?
5.	☐	☐	Hay fever or allergy?	16.	☐	☐	Suicide attempt?
6.	☐	☐	Asthma or lung disease?	17.	☐	☐	Motion sickness requiring medication?
7.	☐	☐	Heart or vascular trouble or HIV?	18.	☐	☐	Medical rejection by any organization?
8.	☐	☐	High or low blood pressure?	19.	☐	☐	Rejection for life or medical insurance?
9.	☐	☐	Stomach, liver, or intestinal trouble?	20.	☐	☐	Admission to hospital?
10.	☐	☐	Kidney stone or blood in the urine?	21.	☐	☐	Other illness, disability or surgery? (*attach report*)
11.	☐	☐	Diabetes?	22.	☐	☐	Use contact lenses for near vision during flying?

G. CONVICTION AND/OR ADMINISTRATIVE ACTION HISTORY:

1. ☐ **YES** ☐ **NO** 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** ☐ **NO** History of non-traffic conviction(s)? (misdemeanors or felonies)

H. EXPLANATIONS: (*Use Form 548-2 for additional explanations)*

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

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

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

BASR Regulation [Penalty $3000 or 2 years in prison] *A person shall not with intent to deceive: (c) 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

K. GENERAL EXAMINATION:

1. Height *(cm)*	2. Weight *(kgs)*	3. Waiver of Demonstrated Ability (WODA)? (a) ☐ **YES** (b) ☐ **NO** **D**efect Noted➔	4. WODA Serial Number➔

	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 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, coordination, 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

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

L. HEARING:

1. Conversational Voice Test (at 5 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)

M. VISION:

1. Distant Vision	2. Near Vision	3. Intermediate Vision *(32 inches)*	4. Color Vision
a. Right= 20/ Corrected to 20/	a. Right= 20/ Corrected to 20/	a. Right= 20/ Corrected to 20/	(a) ☐ Pass
b. Left= 20/ Corrected to 20/	b. Left= 20/ Corrected to 20/	b. Left= 20/ Corrected to 20/	(b) ☐ Fail
c. Both= 20/ Corrected to 20/	c. Both= 20/ Corrected to 20/	c. Both= 20/ Corrected to 20/	

5. Field of Vision	6, Heterophoria 20' (in prism diopters)	Esophoria	Exsophoria	Right Hyperphoria	Left Hyperphoria
. ☐ Normal ☐ Abnormal					

N. CARDIOVASCULAR:

1. Blood Pressure *(30"Hg)* (a) Systolic➔ (b) Diastolic➔ 2. Pulse (Resting)➔ 3. ECG (Date)➔

O. URINALYSIS:

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

P. OTHER MEDICAL TESTS GIVEN

Q. 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, Xrays, etc. to this report before mailing.*

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

R. MEDICAL EXAMINER'S ANALYSIS & DECISION

1. ☐ ISSUANCE RECOMMENDED 2. ☐ DEFER FOR FURTHER EVALUATION 3. ☐ ISSUANCE NOT RECOMMENDED 4. ☐ DENIAL LETTER ISSUED

Disqualifying Defects:

S. MEDICAL DECLARATION: ***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*:**

1. Date of Examination	2. AME SERIAL NUMBER	3. AME PRINTED NAME
_____ DD / MM / YYYY	4. AME TELEPHONE #	5. AME SIGNATURE