

## APPLICATION FORM FOR A MEDICAL CERTIFICATE

Complete this page fully and in block capitals - Refer to instructions for completion.

MEDICAL IN CONFIDENCE

(1) State of licence issue:		(2) Medical certificate applied for: CC class 1 <input type="checkbox"/> class 2 <input type="checkbox"/> LAPL <input type="checkbox"/> class 3 <input type="checkbox"/>	
(3) Surname:		(4) Previous surname(s):	(12) Application: Initial Revalidation/Renewal
(5) Forename(s):		(6) Date of Birth All dates = (ddmm yyyy):	(7) Sex: Male Female
(8) Place and country of birth:		(9) Nationality:	(13) Reference number:
(10) Permanent address: Country: Telephone No: Mobile No: E-mail:		Information on general practitioner (as specified on your Health Insurance Card) Name of GP: Address: Telephone No.:	(11) Postal address (if different): Country: Telephone No.:
(14) Licence(s) held (type): Licence number: State of issue:		(15) Occupation (principal): (16) Employer: (17) Last medical examination: Date: Place:	(18) Any limitations on licence(s)/medical certificate held. No Yes Details
(20) Have you ever had a medical certificate denied, suspended or revoked by any licensing authority? No Yes Date: Country: Details:		(21) Flight time total: (22) Flight time since last medical: (23) Aircraft class/type(s) presently flown:	(19) Any limitations on licence(s)/medical certificate held. No Yes Details
(24) Any aviation accident or reported incident since last medical examination? No Yes Date: Place: Details:		(25) Type of flying intended: (26) Present flying activity: Single pilot Multi pilot	(27) Do you drink alcohol? No Yes, amount
(29) Do you smoke tobacco? No, never No, date stopped: Yes, state type and amount:		(28) Do you currently use any medication? No Yes State medication, dose, date started and why:	

**General and medical history: Do you have, or have you ever had, any of the following? Please tick (X) and if yes, give details in remarks section (30)**

Yes No		Yes No		Yes No		Family history of:		Yes No	
101 Eye trouble/eye operation		112 Nose, throat or speech disorder		123 Malaria or other tropical disease		170 Heart disease			
102 Spectacles and/or contact lenses ever worn		113 Head injury or concussion		124 A positive HIV test		171 High blood pressure			
		114 Frequent or severe headaches		125 Sexually transmitted disease		172 High cholesterol level			
103 Spectacle/contact lens prescriptions change since last medical exam.		115 Dizziness or fainting spells		126 Sleep disorder/apnoea syndrome		173 Epilepsy			
		116 Unconsciousness for any reason		127 Musculoskeletal illness/impairment		174 Mental illness			
104 Hay fever, other allergy		117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.		128 Any other illness or injury		175 Diabetes			
105 Asthma, lung disease			129 Admission to hospital		176 Tuberculosis				
106 Heart or vascular trouble		118 Psychological/psychiatric trouble of any sort		130 Visit to medical practitioner since last medical examination		177 Allergy/asthma/eczema			
107 High or low blood pressure			131 Refusal of life insurance			178 Inherited disorders			
108 Kidney stone or blood in urine		119 Alcohol/drug/substance abuse		132 Refusal of flying licence		179 Glaucoma			
109 Diabetes, hormone disorder		120 Attempted suicide		133 Medical rejection from or for military service		<b>Females only:</b>			
110 Stomach, liver or intestinal trouble		121 Motion sickness requiring medication			134 Award of pension or compensation for injury or illness		150 Gynaecological, menstrual problems		
111 Deafness, ear disorder		122 Anaemia/sickle cell trait/other blood disorders				151 Are you pregnant?			

(30) **Remarks:** If previously reported and no change since, so state.

**(31) Samtykkeerklæring (der indhentes både helbredsoplysninger og kriminalregisterets oplysninger):**

I hereby declare that I have carefully considered the statements made above and to the best of my belief they are complete and correct and 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 fail to release the supporting medical information, the licensing authority may refuse to grant me a medical certificate or may withdraw any medical certificate granted, without prejudice to any other action applicable under national law.

CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby authorise the release of all information contained in this report and any or all attachments to the AME and, where necessary, to the medical assessor of the licensing authority, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. Medical confidentiality will be respected at all times.

.....  
Date

.....  
Signature of applicant

.....  
Signature of AME / (Medical assessor)