Application form for Aviation Medical Certificate

Medical in confidence

DADL ATTEST 03.12.02.01 – TCL – JUN 2009

Complete the form in blocks by the applier or by the doctor with the applier. See Instructions

(1) JAA State of licence issue:
Trafikstyrelsen, Personcertificering, Edvard Thomsens Vej 14, 2300 København S

(2) Class of medical certificate applied for:
Class 1 ☐ Class 2 ☐ Others ☐

(3) Surname:

(4) Previous surname:

(12) Application Initial ☐
Renewal/Revalidation ☐

(5) First name:

(6) Date o

(7) Male ☐
Female ☐

(13) Reference number :

(8) Fødested/Land:

(9) Nationality:

(15) Occupation:

(10) Permanent adress:
Country Phone:
E-mail:

(11) Postal adress:
Country: Phone:
E-mail:

(16) Employer:

(17) Last medical Examination:
Date:
Place:

(18) Aviation licence(s) held (type):

Licence number:

Country of iss

(19) Any conditions/Limitations/Variations on the Licence/Medical Cert.: No ☐
Yes ☐ Which:

(20) Have you ever had an aviation medical certificate denied, suspected or revoked by any licensing authoprity
No ☐ Yes ☐ Country: Date:
Details:

(21) Total flight hours:

(22) Flights time since last medical:

(23) Aircraft type presently flown:

(24) Any aircraft accident or reported incident since last medical?
No ☐ Yes ☐ Country: Date:
Details:

(25) Type of flying intended:

(26) Present flying activity:
Single pilot ☐ Multi pilot ☐

(27) Alcohol - state avage weekly intake in units:

(28) Do you currently use any medication?
No ☐ Yes ☐ State drug dose date started and why:

(29) Soke tobacco? Never ☐ No ☐ Date stopped:
Yes ☐ State type and amount:

General and medical history: Do you have or ever had any of the following? YES or NO (or as indicated) must be ticked after each question. Elaborate YES answers

	Ja	Nej		Ja	Nej		Ja	Nej	**Sickness in family**	Ja	Nej
101 Eye trouble/ eye operation	☐	☐	**114** Frequent or severe headaches	☐	☐	**125** Sexually transmitted disease	☐	☐	**170** Heart disease	☐	☐
102 Spectacles and/or contact lenses	☐	☐	**115** Dizziness or fainting spells	☐	☐	**126** Admission to hospital	☐	☐	**171** High blood pressure	☐	☐
103 Spectacles/lenses changed since last med. exam	☐	☐	**116** Unconsciousness for any reason	☐	☐	**127** Any other illness or injury	☐	☐	**172** High cholesterol level (lipider)	☐	☐
104 Allergy or hay fever	☐	☐	**117** Neurological disorder, stroke, epilepsy, seizure, paralysis etc.	☐	☐	**128** Doctor visit since last medical examination	☐	☐	**173** Epilepsi	☐	☐
105 Ashma, lung disease	☐	☐							**174** Mental illness	☐	☐
106 Heart or vascular trouble	☐	☐	**118** Psychological, depression, anxity sleep trouble, etc.	☐	☐	**129** Refusal of life insurance	☐	☐	**175** Diabetes	☐	☐
107 High or low blod pressure	☐	☐	**119** Alcohol-, drug-, or substance abuse	☐	☐	**130** Refusal of flying licence	☐	☐	**176** Tuberculosis	☐	☐
108 Kidney stone, blood in urine	☐	☐	**120** attemped suicide	☐	☐	**131** Traffic offences influenced by alcohol use	☐	☐	**177** Allergy/asthma/eczeme	☐	☐
109 Diabetes, hormone disorder	☐	☐	**121** Medicated for motion sickness	☐	☐				**178** Any inherited disorders	☐	☐
110 Stomac, liver or intestinal trouble	☐	☐	**122** Malaria or other tropical disease	☐	☐	**132** Medical rejection for military	☐	☐	**179** Glaucoma	☐	☐
111 Deafness, ear disorder	☐	☐							**Only women**		
112 Nose- throat or speech disorder	☐	☐	**123** Anaemia/ sickle cell trait/ other blood disorder	☐	☐	**133** Award of pension or compen-sasion for injury or illness	☐	☐	**150** Gynecological/menstrual disord	☐	☐
113 Head injury or, concussion	☐	☐	**124** A positive HIV test	☐	☐				**151** Pregnant?	☐	☐
									If yes, date of last menses?		

(30) Remarks: If previously reported and change since, so state:

(31) Declaration: I hereby declare that I have carefully considered the statements made above and to the best of my beliefs 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 Authority may refuse to grane me a medical certificate or may withdraw any medical certificate granted, without prejustice to any other action applicate under antional 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 Medical sektion and if necessary the Medical sector of any other State knowing that these documents or electronically stored data are to be used fore completion of a medical and will become and remain the property of the authority providing that I or my physician may have acces to them according to national law. Medical Confidentiality will be respected at all times.

Date ____________ Signature of applicant ____________ Signature of AME (witness) ____________

Forward to:
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