APPLICATION FORM FOR A MEDICAL CERTIFICATE - Class 1, Class 2 & LAPL

Civil Aviation Directorate

Transport Malta – Civil Aviation Directorate Pantar Road, Lija, LJA 2021, Malta. Tel:+356 2555 5000 ams.tm@transport.gov.mt www.transport.gov.mt

MEDICAL IN CONFIDENCE

Complete this page fully and in BLOCK CAPITALS – Refer to instructions for completion

(1) State of licence issue:	(2) Medical certificate applied for: Class 1 ☐ Class 2 ☐ LAPL ☐	
(3) Surname:	(4) Previous surname(s):	(12) Application Initial ☐ Revalidation/Renewal ☐
(5) Forename(s):	(6) Date of birth (dd/mm/yyyy): / (7) Sex Male ☐ Female ☐	(13) Reference number:
(8) Place and country of birth:	(9) Nationality:	(14) Type of licence applied for:
(10) Permanent address: Country: Telephone No.: Mobile No.: e-mail:	(11) Postal address (if different): Country: Telephone No.:	(15) Occupation (principal): (16) Employer: (17) Last medical examination: Date: Place:

(18) Aviation licence(s) held (type): Licence number: State of issue:	(19) Any limitations on licence(s)/medical certificate held No ☐ Yes ☐ Details:
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? No ☐ Yes ☐ Date: Country: Details:	(21) Flight time hours total: / (22) Flight time hours since last medical: 23) Aircraft class/type(s) presently flown:
(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	(28) Do you currently use any medication? No ☐ Yes ☐ State drug, dose, date started and why:
(29) Do you smoke tobacco? ☐No, never ☐No, date stopped: ☐Yes, state type and amount:	

General and medical history: Do you have, or have you ever had, any of the following? (Please tick). 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 or suicide		
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									178 Inherited disorders		
108 Kidney stone or blood in urine			119 Alcohol/drug/substance abuse			131 Refusal of life insurance			179 Glaucoma		
109 Diabetes, hormone disorder			120 Attempted suicide, or self-harm			132 Refusal of flying licence					
110 Stomach, liver or intestinal trouble			121 Motion sickness requiring medication			133 Medical rejection from or for military service			**Females only:**		
111 Deafness, ear disorder			122 Anaemia/sickle cell trait/other blood disorders			134 Award of pension or compensation for injury or illness			150 Gynaecological, menstrual problems		
									151 Are you pregnant?		

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

(31) **Declaration:** 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 my licensing authority, to the medical assessor of the competent authority of my AME and to the relevant medical professionals for the purpose of completion of an aero-medical assessment or a secondary review, 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.

NOTIFICATION OF DICLOSURE OF PERSONAL DATA: I hereby declare that I have been informed and I understand that the data contained in my medical certificate according to ARA.MED.130 may be electronically sorted and made available to my AME in order to provide historical date required in MED.A.035(b)(2)(ii)/(iii) and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of ARA.MED.150(c)(4).

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Date Signature of applicant Signature of AME/(medical assessor)