1. APPLICATION FORM FOR MEDICAL CERTIFICATE

2. CLASS OF MEDICAL CERTIFICATE APPLIED FOR ☐ 1st ☐ 2nd ☐ 3rd

3. Name in full	4. Identification #	Citizenship

5. Address

6. Date of Birth DD/MM/YYYY	7. Hair Colour	8. Eye Colour	9. Sex

10. Type of licence you hold:

☐ None	☐ ATC Specialist	☐ Flight Instructor	☐ Balloon
☐ Airline Transport	☐ Flight Engineer	☐ Private	☐ Glider
☐ Commercial	☐ Flight Navigator	☐ Student	☐ Other

11. Occupation	12. Employer	Telephone Number

13. Has your CASAS Airman Medical Certificate ever been denied, suspended or revoked?
☐ Yes ☐ No If yes, give date / /

Total pilot time (Civilian Only)		16. Date of Last CASAS Medical Application	
14. To Date	15. Past 6 Months	DD / MM / YYYY	☐ No prior application

17a. Do you currently use any medication (prescription or non-prescription)
☐ No ☐ Yes (if yes, list medication(s) used and indicate whether previously reported)

Medication	Previously Reported	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

17b. Do you ever use near vision contact lens(es) when flying? ☐ Yes ☐ No

18a. MEDICAL HISTORY – HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR, DO YOU HAVE PRESENTLY 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 Instruction Page.**

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a ☐	☐	Frequent or severe headaches	g ☐	☐	Heart or vascular trouble	m ☐	☐	Mental disorders of any sort; anxiety depression, etc.	s ☐	☐	Medical rejection by military service
b ☐	☐	Dizziness of fainting spells	h ☐	☐	High or low blood pressure	n ☐	☐	Substance abuse or dependence, or failed a drug test ever, or use of illegal substance(s)	t ☐	☐	Rejection for life or health insurance
c ☐	☐	Unconsciousness for any reason	i ☐	☐	Stomach, liver or intestinal trouble	o ☐	☐	Alcohol abuse or dependence; failed an alcohol test	u ☐	☐	Admission to hospital
d ☐	☐	Eye or vision trouble except glasses	j ☐	☐	Kidney stone or blood in urine	p ☐	☐	Suicide attempt	x ☐	☐	Other illness, disability or surgery
e ☐	☐	Hay fever or allergy	k ☐	☐	Diabetes	q ☐	☐	Motion sickness medication required			
f ☐	☐	Asthma or lung disease	l ☐	☐	Neurological disorders, epilepsy, seizures, stroke, paralysis, etc.	r ☐	☐	Military medical discharge			

Explanations: See Instruction Page

18b. FAMILY MEDICAL HISTORY – DOES ANY THE FOLLOWING PERTAIN TO YOUR FAMILY’S MEDICAL HISTORY?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a ☐	☐	Heart Disease	g ☐	☐	High Cholesterol levels	m ☐	☐	Epilepsy	s ☐	☐	Mental Illness
b ☐	☐	High Blood Pressure	h ☐	☐	Diabetes	n ☐	☐	Tuberculosis	t ☐	☐	Allergies/Asthma/Eczema
c ☐	☐	Inherited Disorders	i ☐	☐	Glaucoma	o ☐	☐		u ☐	☐	

19. Visit to health professional within the last 3 years ☐ Yes (Explain below) ☐ No **See Instruction Page**

Date	Name, Address, and Type of Health Professional Consulted	Reason

20. I hereby certify that all statements and answers provided by me on this application are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any CAA licence and certificate to me.	Signature of Applicant	Date

NOTE:/Original Copy of Medical Examination Must be TYPED.

REPORT OF MEDICAL EXAMINATION

21. Height (cm)	22. Weight (kg)	Statement of Demonstrated Ability (SODA) ☐ Yes ☐ No Defect Noted:	24. SODA No

CHECK EACH ITEM IN APPROPRIATE COLUMN	Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN	Normal	Abnormal
25 Head, face, neck and scalp			37 Vascular system (Pulse, amplitude and character, arms, legs, others)		
26 Noses			38 Abdomen and viscera (including hernia)		
27 Sinuse7			39 Anus (not including digital examination)		
28 Mouth and Throat			40 Skin		
29 Ears, general (internal and external canals, Hearing under item 49			41 G-U System (Not including pelvic examination)		
30 Ear Drums (Perforation)			42 Upper and lower extremities (Strength and range of motion)		
31 Eyes, general (Vision under items 50 to 54)			43 Spine, other musculoskeletal		
32 Ophthalmoscopic			44 Identifying body marks, scars, tattoos (size and location)		
33 Pupils (Equality and reaction)			45 Lymphatics		
34 Ocular motility (Associated parallel movement, nystagmus)			46 Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc)		
35 Lungs and chest (not including breast examination)			47 Psychiatric (Appearance, behaviour, mood, communication, and memory)		
36 Heart (Precordial activity, rhythm, sounds, and murmurs)			48 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.

49. Hearing	Record Audiometric Speech Discrimination Score Below		Right Ear					Left Ear				
Conversational Voice Test at 2 meters ☐ Pass ☐ Fail		Audiometer Threshold in decibels	500	1000	2000	3000	4000	500	1000	2000	3000	4000

50. Distant Vision	51a. Near Vision	51b. Intermediate Vision	52. Colour Vision
Right / Corrected to /	Right / Corrected to /	Right / Corrected to /	☐ Pass
Left / Corrected to /	Left / Corrected to /	Left / Corrected to /	☐ Fail
Both / Corrected to /	Both / Corrected to /	Both / Corrected to /	**Mode used:**

53. Field of Vision	54. Heterophoria 20' (in prism dioptres)	Esophoria	Exophoria	Right Hyperphoria	Left Hyperphoria
☐ Normal ☐ Abnormal					

55. Blood Pressure	56. Pulse (Resting)	57. Urinalysis (if abnormal, give results)	Albumin	Sugar	58. ECG (Date)
Systolic / Diastolic (Sitting, mm of Mercury)		☐ Normal ☐ Abnormal			DD MM YYYY

59. Other tests given

60. 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, X-rays, etc. to this report before mailing).	FOR CASAS USE
	Pathology Codes:
	Coded By:
Significant Medical History ☐ Yes ☐ No Abnormal Physical Findings ☐ Yes ☐ No	Clerical Reject

61. Applicant's Name	62 Medical Assessment: ☐ Fit ☐ Temporary unfit ☐ Unfit ☐ Deferred for further evaluation

63. Disqualifying Defects (List by item number)

64. Medical Examiner's Declaration – I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medial examination report. This report with any attachment embodies my findings completely and correctly.

Aviation Medical Examiner's Signature	Aviation Medical Examiner's Name	Aviation Medical Examiner's Signature
ADDRESS		AME Number
		AME Telephone