



Section/division **AVMED**
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 Postal address: **Private Bag X73, Halfway House 1685** Website: **www.caa.co.za**

Form Number: CA 67-02(a)
 Fax Number:

AVIATION MEDICAL REPORT

PERSONAL INFORMATION

1. Surname		First name(s)					
2. Postal address				Postal code			
3. Telephone numbers		During office hours		Cell No.		E-mail	
4. Date of birth (dd/mm/yyyy)				5. Nationality			
6. Identity/Passport No.				7. Gender			
8. Occupation				9. Medical Class applied for			
10. Licence Number		11. Licence Type		12. Type of flying Intended:		Single-Crew <input type="checkbox"/> Multi-crew <input type="checkbox"/>	
Flight time (hours)			Type of flying intended			Previous medical examination	
Last 6 months	Last 12 months	Total	Recreation	Business	Career	Doctor	Date
13. Have you ever had an aviation Medical Assessment denied, suspended or revoked by any licence authority? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes Discussed with Medical Examiner: _____ Date: _____ Place: _____ Details: _____							
14. Any aircraft /vehicle accident or reported incident since last medical? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Place: _____ Details: _____							
15. Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, state average weekly intake in units: _____				16. Do you smoke tobacco products? Never <input type="checkbox"/> Previously <input type="checkbox"/> Currently <input type="checkbox"/> Date stopped: _____ State type, amount and number of years: _____			
17. Do you currently use any medication, including non-prescribed medication? (Please attach additional pages if space is insufficient.) Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, state the name of medication, date commenced, daily or weekly dose, and diagnosis							
14. Any limitations on licence / Restrictions? Yes <input type="checkbox"/> No <input type="checkbox"/> Details: _____							

ID Number/Passport No.		Date	
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MEDICAL HISTORY			Y	N	Y	N
<i>Do you have, or have you ever had, any of the following? Yes or No must be ticked after each question</i>						
1. Eye disorders / eye surgery			19. Psychological / psychiatric trouble of any sort			
2. Spectacles and/or contact lenses ever worn			20. Alcohol / drug / substance abuse			
3. Spectacles / contact lens prescriptions/change since last medical exam			21. Attempted suicide			
4. Hay fever or other allergies			22. Motion sickness requiring medication			
5. Asthma / lung disease			23. Anaemia / Sickle cell trait / other blood disorders			
6. Heart or vascular disease			24. Malaria or other tropical diseases			
7. High or low blood pressure			25. A positive HIV test			
8. Kidney stone or blood in urine			26. Sexually transmitted disease			
9. Diabetes / other hormone disorder			27. Bleeding from the rectum			
10. Stomach / liver / intestinal trouble			28. Gynaecological disorder (including menstrual / pregnancy)			
11. Deafness / ear disease			29. Prostate Problems			
12. Admitted to hospital			30. Malignant tumour or Cancer			
13. Nose or throat disease or speech disorder			31. Any other illness or injury			
14. Head injury or concussion			32. Visit to medical practitioner since last medical examination			
15. Frequent or severe headaches			33. Refusal of life insurance			
16. Dizziness or Fainting spells			34. Refusal of issue or revocation of aviation licence			
17. Unconsciousness (for any reason)			35. Medical rejection from or for military service			
18. Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.			36. Award of pension or compensation for injury or illness			
FAMILY HISTORY OF:	Y	N		Y	N	
37. Heart disease			42. Diabetes			
38. High blood pressure			43. Tuberculosis			
39. High cholesterol level			44. Allergy / asthma / eczema			
40. Epilepsy			45. Inherited disorders			
41. Mental illness			46. Glaucoma			

REMARKS	
<i>Aviation Medical Examiner to comment in full on all items marked YES. Please attach additional pages if space is insufficient.</i>	

NOTICE

Any person, who makes, either orally or in writing, a false or misleading statement in or in connection with any application for a licence, certificate or rating issued under these regulations or any return furnished in accordance with any requirement of these regulations, shall be guilty of an offence. (Civil Aviation Regulations (CAR), Part 185.001.1(1)(di-dii))

DECLARATION BY APPLICANT

I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete and correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statement in connection with this application, or if I do not consent to release the support the supporting medical information, the Authority may refuse to grant me Medical Assessment or may withdraw any Medical Assessment granted, without prejudice to any other legal action applicable pursuant (CAR, Part...)

Consent to release of medical information: I hereby give my consent that all relevant medical information may be released and submitted to the Medical Assessor of the Licensing Authority. **Note:** Medical Confidentiality will be respected at all times

SIGNATURE OF APPLICANT	NAME IN BLOCK LETTERS	DATE
SIGNATURE OF AME (AS WITNESS)	NAME IN BLOCK LETTERS	DATE

ID Number/Passport No.	Date	
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