CIVIL AVIATION AUTHORITY OF MALAYSIA

APPLICATION FORM FOR AVIATION MEDICAL CERTIFICATE

Complete this page fully using a black ball point pen and in block letters

MEDICAL IN CONFIDENCE

(1) FULL NAME:			(2) Licence Number: File Number:	
(3) Type of licence applied for: ATPL ☐ CPL ☐ RePL ☐ PPL ☐ SPL ☐ ATC ☐			(4) Class of certificate applied for: 1st ☐ 2nd ☐ 3rd ☐	
(5) NRIC/Passport Number:	(6) Date of Birth:	(7) Age:	(8) Sex: Male ☐ Female ☐	(9) Application: Initial ☐ Renewal ☐ Special (CAMB, reinstatement) ☐
(10) Place and country of birth:	(11) Nationality:		(12) Occupation (principal):	
(13) Permanent address: Country: Telephone No: Mobile No: E-mail:	(14) Postal address (if different) Country: Telephone No: Mobile No: E-mail:		(15) Employer: (16) Last medical examination Date: Place: (17) Aviation licence(s) held (type): Licence number: Country of issue:	
(18) GP Name: Address: Telephone Number:			(19) Any Conditions/Limitations/Variations on the Licence/Medical Certificate? NO ☐ YES ☐ Details:	
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with DME. YES ☐ NO ☐ Date: Place: Details:			(21) Flight time total: N/A ☐	(22) Flight time since last medical: N/A ☐
(23) Any aviation accident or reported incident since last medical examination? Date: Place: Details:			(24) Aircraft Class /Type(s) presently flown: N/A ☐ (25) Type of flying intended: N/A ☐	
(26) Type of flying intended (2): Single pilot ☐ Multi pilot ☐			ATCO Activity intended: Aerodrome ☐ Area procedural ☐ Approach procedural ☐ Area surveillance ☐ Approach surveillance ☐ Others ☐	
(27) Alcohol – state average weekly intake in units:				
(28) Do you smoke tobacco? NEVER ☐ NO ☐ YES ☐ STOP ☐ Date stopped: State type, amount & number of years:				
(29) Do you currently use any medication? NO ☐ YES ☐ If YES, state medication, dose, date started and why.				

CIVIL AVIATION AUTHORITY OF MALAYSIA

APPLICATION FORM FOR AVIATION MEDICAL CERTIFICATE

MEDICAL IN CONFIDENCE

Complete this page fully using a black ball point pen and in block letters
General and medical history: Do you have, or have you ever had, any of the following? YES or NO (or as indicated) must be ticked after each question. Elaborate YES answers in the remarks section.

	Yes	No		Yes	No		Yes	No		Yes	No
(30) Eye trouble/eye operation			(41) Nose, throat or speech disorder			(52) Malaria or other tropical disease			**Females only:**		
(31) Spectacles and/or contact lenses ever worn			(42) Head injury or concussion			(53) A positive HIV test			(64) Gynecological, menstrual problems		
(32) Spectacle/contact lens prescriptions/change since last medical exam			(43) Frequent or severe headaches			(54) Sexually transmitted disease			(65) Are you pregnant?		
(33) Hay fever, other allergies			(44) Dizziness or fainting spells			(55) Admission to hospital			**Family history of:**		
(34) Asthma, lung disease			(45) Unconsciousness for any reason			(56) Any other illness or injury			(66) Heart disease		
(35) Heart or vascular trouble			(46) Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			(57) Visit to medical practitioner since last medical examination			(67) High blood pressure		
(36) High or low blood pressure			(47) Psychological/psychiatric trouble of any sort			(58) Sleep Apnea			(68) High cholesterol level		
(37) Kidney stone or blood in urine			(48) Alcohol/drug/substance abuse			(59) Musculoskeletal illness			(69) Epilepsy		
(38) Diabetes, hormone disorder			(49) Attempted suicide			(60) Refusal of Life insurance			(70) Mental illness		
(39) Stomach, liver or intestinal trouble			(50) Motion sickness requiring medication			(61) Refusal of Flying licence / ATCOl icence			(71) Diabetes		
(40) Deafness, ear disorder			(51) Anemia/Sickle cell trait/other blood disorders			(62) Medical rejection from or for military service			(72) Tuberculosis		
						(63) Award of pension or compensation for injury or illness			(73) Allergy/asthma/eczema		
									(74) Inherited disorders		
									(75) Glaucoma		

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

(77) **Declaration**: I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. 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 CAAM 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.

I hereby authorize the release of all information contained in this report and any or all its attachments and all information which I have provided to the CAAM and that relates to me to my DME and, where necessary, to:

i. the Medical Assessor of CAAM; and
ii. the Medical Assessor of the competent authority of my DME; and
iii. other health professionals and administration staff

as part of the medical assessment process. I recognize that these documents or electronically stored data are to be used for completion of a medical assessment and for oversight purposes, providing that I or my physician may have access to them according to national law. The medical record will become and remain the property of the CAAM. Medical confidentiality will be respected at all times.

----------	----------	----------
Date	Name and signature of applicant	Signature, name and stamp of DME (Witness)

INSTRUCTION PAGE FOR COMPLETION OF THE APPLICATION FORM FOR AN AVIATION MEDICAL ASSESSMENT

This Application Form, all attached Report Forms and Reports are required in accordance with Malaysian Civil Aviation Regulations and Civil Aviation Directives 1 – Personnel Licensing and will be transmitted to the Medical Assessor of the CAAM. Medical confidentiality will be respected at all times.

The Applicant must personally complete in full all questions (boxes) on the Application Form. Writing must be in Block letters with a black ballpoint pen and must be legible. Exert sufficient pressure to make legible copies. If more space is required to answer any question, use a plain sheet of paper with the additional information, your signature and the date. The following numbered instructions apply to the numbered headings on the application form.

NOTICE.— Failure to complete the application form in full or to write legibly will result the application form not being accepted. The making of False or Misleading statements or the Withholding of relevant information in respect of this application may result in criminal prosecution, refusal of this application and/or withdrawal of any Medical Assessment(s) previously granted.

1. FULL NAME *State first name and surname / family name*	15. EMPLOYER (principal): *State principal employer.*
2. LICENCE NUMBER *Current licence number (if not initial application)*	16. LAST MEDICAL EXAMINATION: *State date (dd/mmm/yyyy) and place (city/town and country) of last aviation medical examination. Initial applicants state "NONE".*
3. TYPE OF LICENCE APPLIED FOR (if initial application): *if applying for the first issuance of a licence to the CAAM, please state type of licence applied for.*	17. AVIATION LICENCE(S) HELD (TYPE). LICENCE NUMBER(S), COUNTRY(IES) OF ISSUE: *Provide information concerning licences already held.*
4. CLASS OF MEDICAL CERTIFICATE APPLIED FOR: *Tick appropriate box*	18. GENERAL PRACTITIONER NAME AND ADDRESS (if applicable) *Provide contact details of family physician.*
5. NRIC/PASSPORT NUMBER *(where applicable): State your NRIC number or passport number of your country of citizenship.*	19. ANY LIMITATION ON THE LICENCE/MEDICAL ASSESSMENT: *Tick appropriate box and provide details of any limitations on your licence(s) and/or medical certificate(s), e.g. correcting lenses, valid day-time only, multi-pilot operations only.*
6. DATE OF BIRTH *Specify in order (DD/MMM/YYYY).*	20. HAVE YOU EVER HAD AN AVIATION MEDICAL ASSESSMENT DENIED, SUSUPENDED OR REVOKED BY ANY LICENSING AUTHORITY? IF YES, DISCUSS WITH THE MEDICAL EXAMINER: *Tick "Yes" if you have ever had a Medical Assessment denied, suspended or revoked, even if temporarily. Provide the date, place and details, and discuss with the Medical Examiner.*
7. AGE: *State your age.*	21. TOTAL FLIGHT TIME (HOURS): *For pilots, state total number of hours flown in an operating capacity. Non-pilots state "Not applicable".*
8. SEX *Tick appropriate box.*	22. FLIGHT TIME (HOURS) SINCE LAST MEDICAL EXAMINATON: *State number of hours flown in an operating capacity since last aviation medical examination.*
9. APPLICATION *Tick appropriate box. Tick "initial" if this is your first application to CAAM, even if you hold other similar licences issued by another Authority.*	23. ANY AIRCRAFT ACCIDENT OR REPORTED INCIDENT SINCE LAST MEDICAL EXAMINATION? *If "Yes" provide details.*
10. PLACE AND COUNTRY OF BIRTH *State city/town and country of birth.*	24. AIRCRAFT CURRENTLY FLOWN: *State the name of aircraft currently flown e.g. B737, A330, Cessna 150.*
11. NATIONALITY *State name of country of citizenship*	25. TYPE OF FLYING INTENDED (1): *Provide details of intended flying e.g. commercial air transport, flying instruction, private.*
12. OCCUPATION (principal): *State principal occupation.*	26. TYPE OF FLYING INTENDED (2) / ATCO ACTIVITY INTENDED: *Tick appropriate box(es).*
13. PERMANENT ADDRESS: *State main place of residence, with contact details, telephone number(s) and e-mail address.*	27. IF YOU DRINK ALCOHOLIC BEVERAGES STATE AVERAGE WEEKLY INTAKE IN UNITS: *State weekly intake e.g. 12 units (beer and wine). Note: 1 unit ~ 12 g alcohol; this corresponds to the amount of alcohol in a standard (0.34L) can or bottle of beer, a glass of wine, etc.*
14. POSTAL ADDRESS (if different from Permanent Address): *If relevant, state postal address and telephone number.*	28. DO YOU SMOKE TOBACCO PRODUCTS? *Tick applicable box. Current smokers should state type and amount e.g. 20 cigarettes per day; pipe, 30 grams weekly.*

29. DO YOU CURRENTLY USE ANY MEDICATION INCLUDING NON-PRESCRIBED MEDICATION? *State medications prescribed by a medical practitioner and also non-prescribed medication e.g. herbal remedies, medications bought without prescription ("over the counter"). If "Yes" is ticked, provide details: name of medication, date treatment was commenced, daily/weekly dose and the condition or problem for which the medication is taken.*	30. GENERAL AND MEDICAL HISTORY: *All items under this heading from number 30 to 75 inclusive must have the answer 'YES' or 'NO' ticked. You MUST tick 'YES' if you have ever had the condition in your life and describe the condition and approximate date in the REMARKS box. All questions asked are medically important even though this may not be readily apparent. Items numbered 66 to 75 relate to immediate family history. If information has been reported on a previous application form to the Medical Examiner issuing the Medical Assessment applied for and there has been no change in your condition, you may state 'Previously Reported, Unchanged'. However, you must still tick YES' to the condition. Do not report occasional common self-limiting illnesses such as colds.*
77. DECLARATION AND CONSENT TO RELEASE OF MEDICAL INFORMATION: *Do not sign or date this section until indicated to do so by the Medical Examiner who will act as witness and sign accordingly.*	

AN APPLICANT HAS THE RIGHT TO REFUSE ANY EXAMINTION AND TEST AND TO REQUEST REFERRAL TO THE CIVIL AVIATION AUTHORITY OF MALAYSIA.

HOWEVER, THIS MAY ENTAIL TEMPORARY DENIAL OF MEDICAL CERTIFICATION.