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:										(4) Class of certificate applied for:					
ATPL		CPL		RePL		PPL		SPL		ATC		1st		2nd		3rd	

(5) NRIC/Passport Number:	(6) Date of Birth:	(7) Age:	(8) Sex:		(9) Application:	
			Male		Initial	
					Renewal	
			Female		Special	
					(CAMB, reinstatement)	

(10) Place and country of birth:	(11) Nationality:	(12) Occupation (principal):

(13) Permanent address:	(14) Postal address: (if different)	(15) Employer:
		(16) Last medical examination
		Date:
		Place:
		(17) Aviation licence(s) held (type):
Country: Telephone No: Mobile No: E-mail:	Country: Telephone No: Mobile No: E-mail:	Licence number: Country of issue:

(18) GP Name:	19) Any Conditions/Limitations/Variations on the Licence/Medical Certificate?			
	No		Yes	
Address: Telephone Number:	Details: Telephone Number:			

(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with DME.				(21) Flight time total:	(22) Flight time since last medical:
Yes		No			
Date:		Place:			
Details:				N/A	N/A:

(23) Any aviation accident or reported incident since last medical examination?			(24) Aircraft Class /Type(s) presently flown:	(25) Type of flying intended:
Date:		Place:		
Details:				

(26) Type of flying intended (2):				ATCO Activity intended:			
Single Pilot		Multi Pilot		Aerodrome		Area procedural	
				Approach procedural		Area surveillance	
				Approach surveillance		Others	

(27) Alcohol – state average weekly intake inunits:							
(28) Do you smoke tobacco?	Never		No		Yes		Stop	
State type, amount & number of years:		Date stopped:					

(29) Do you currently use any medication?	If yes, state medication, dose, date started and why.

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
(30)	Eye trouble / eye operation			(46)	Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			(62)	Medical rejection from or formilitary service		
(31)	Spectacles and/or contact lenses ever worn			(47)	Psychological or psychiatrictrouble of any sort			(63)	Award of pension or compensation for injury or illness		
(32)	Spectacle / contact lens prescriptions / change since last medical exam			(48)	Alcohol / drug / substance abuse			**Females only:**			
(33)	Hay fever, other allergies			(49)	Attempted suicide			(64)	Gynecological, menstrualproblems		
(34)	Asthma, lung disease			(50)	Motion sickness requiring medication			(65)	Are you pregnant?		
(35)	Heart or vascular trouble			(51)	Anemia / Sickle cell trait/other blood disorders			**Family history of:**			
(36)	High or low bloodpressure			(52)	Malaria or other tropicaldisease			(66)	Heart disease		
(37)	Kidney stone or blood inurine			(53)	A positive HIV test			(67)	High blood pressure		
(38)	Diabetes, hormonedisorder			(54)	Sexually transmitted disease			(68)	High cholesterol level		
(39)	Stomach, liver or intestinal trouble			(55)	Admission to hospital			(69)	Epilepsy		
(40)	Deafness, ear disorder			(56)	Any other illness or injury			(70)	Mental illness		
(41)	Nose, throat or speechdisorder			(57)	Visit to medical practitionersince last medical examination			(71)	Diabetes		
(42)	Head injury orconcussion			(58)	Sleep Apnea			(72)	Tuberculosis		
(43)	Frequent or severeheadaches			(59)	Musculoskeletal illness			(73)	Allergy / asthma / eczema		
(44)	Dizziness or faintingspells			(60)	Refusal of Life insurance			(74)	Inherited disorders		
(45)	Unconsciousness for anyreason			(61)	Refusal of Flying licence /ATCO licence			(75)	Glaucoma		

(76) Remarks: If previously reported and no change since, state the reason.

(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*	16	LAST MEDICAL EXAMINATION: *State date (DD-MMM-YYYY) and place (city/town and country) of last aviation medical examination. Initialapplicants state "NONE".*
2	LICENCE NUMBER *Current licence number (if not initial application)*	17	AVIATION LICENCE(S) HELD (TYPE). LICENCE NUMBER(S), COUNTRY(IES) OF ISSUE: *Provide information concerning licences already held.*
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.*	18	GENERAL PRACTITIONER NAME AND ADDRESS (ifapplicable) *Provide contact details of family physician.*
4	CLASS OF MEDICAL CERTIFICATE APPLIED FOR: *Tick appropriate box*	19	ANY LIMITATION ON THE LICENCE/MEDICAL ASSESSMENT: *Tick appropriate box and provide detailsof any limitations on your licence(s) and/or medical certificate(s), e.g. correcting lenses, valid day-time only, multi-pilot operations only.*
5	NRIC/PASSPORT NUMBER *(where applicable):* *State your NRIC number or passport number of your country of citizenship.*	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.*
6	DATE OF BIRTH *Specify in order (DD-MMM-YYYY).*	21	TOTAL FLIGHT TIME (HOURS): *For pilots, state totalnumber of hours flown in an operating capacity. Non-pilots state "Not applicable".*
7	AGE: *State your age.*	22	FLIGHT TIME (HOURS) SINCE LAST MEDICAL EXAMINATON: *State number of hours flown in an operating capacity since last aviation medical examination.*
8	SEX *Tick appropriate box.*	23	ANY AIRCRAFT ACCIDENT OR REPORTED INCIDENT SINCE LAST MEDICAL EXAMINATION? *If"Yes" provide details.*
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.*	24	AIRCRAFT CURRENTLY FLOWN: *State the name ofaircraft currently flown e.g. B737, A330, Cessna 150.*
10	PLACE AND COUNTRY OF BIRTH *State city/town and country of birth.*	25	TYPE OF FLYING INTENDED (1): *Provide details of intended flying e.g. commercial air transport, flying instruction, private.*
11	NATIONALITY *State name of country of citizenship*	26	TYPE OF FLYING INTENDED (2) / ATCO ACTIVITYINTENDED: *Tick appropriate box(es).*
12	OCCUPATION (principal): *State principal occupation.*	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.*
13	PERMANENT ADDRESS: *State main place of residence, with contact details,telephone number(s) and e-mail address.*	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.*
14	POSTAL ADDRESS (if different from Permanent Address): *If relevant, state postal address and telephonenumber*	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.*
15	EMPLOYER (principal): *State principal employer.*	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 importanteven 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.