Inspectie Leefomgeving en Transport

APPLICATION FORM FOR A MEDICAL CERTIFICATE

COMPLETE THIS PAGE FULLY AND IN BLOCK CAPITALS - REFER TO INSTRUCTIONS PAGES FOR DETAILS

Netherlands

Medical in Confidence

(1) State of licence issue:

(2) Class of medical certificate applied for: ☐ 1 ☐ 2 ☐ LAPL ☐ 3 (ATC) ☐ Cabin Crew ☐ Other

(3) Surname:

(4) Previous surname(s):

(5) Forenames:

(6) Date of birth:

(7) Sex: ☐ Male ☐ Female

(8) Place and country of birth:

(9) Nationality:

(10) Permanent address:

Country:
Telephone No.:
Mobile No.:
Email:

(11) Postal address (if different):

Country:
Telephone No.:

(12) Application:
☐ Initial
☐ Renewal/Revalidation

(13) System reference number:

Social Security Number

(14) Type of licence applied for:

(15) Occupation (principal):

(16) Employer:

(17) Last medical examination:
Date:
Place:

(18) Licence(s) held (type): Licence number: Country of issue:

(19) Any Conditions/ Limitations/ Variations on the Licence/ Medical Certificate:
☐ No ☐ Yes
Details:

(20) Have you ever had medical certificate denied, suspended or revoked by any licensing authority?
☐ No ☐ Yes Date: Country:
Details:

(21) Total flight time:

(22) Flight time since last medical:

(23) Aircraft presently flown:

(24) Any aircraft accident or reported incident since last medical?
☐ No ☐ Yes Date: Place:
Details:

(25) Type of flying intended:

(26) Present flying activity:
☐ Single pilot ☐ Multipilot Crew

(27) Alcohol - state average weekly intake in units:

(28) Do you currently use any medication ☐ No ☐ Yes
State medication, dose, date started and why:

(29) Do you smoke tobacco? ☐ Never ☐ No ☐ Yes Date stopped:
State type and amount:

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 remarks section (30).

	Yes	No		Yes	No		Yes	No		Yes	No
(101) Eye trouble/ eye operation	☐	☐	(112) Nose, throat or speech disorder	☐	☐	(123) Malaria or other tropical disease	☐	☐	**Family history of:**		
(102) Spectacles and/or contact lenses ever worn	☐	☐	(113) Head injury or concussion	☐	☐	(124) A positive HIV test	☐	☐	(170) Heart disease	☐	☐
(103) Spectacles/ contact lens prescriptions change since last medical exam.	☐	☐	(114) Frequent or severe headaches	☐	☐	(125) Sexually transmitted disease	☐	☐	(171) High blood pressure	☐	☐
(104) Hay fever, other allergy	☐	☐	(115) Dizziness or fainting spells	☐	☐	(126) Sleep disorder/apnoea syndrome	☐	☐	(172) High cholesterol level	☐	☐
(105) Asthma, lung disease	☐	☐	(116) Unconsciousness for any reason	☐	☐	(127) Musculoskeletal illness/impairment	☐	☐	(173) Epilepsy	☐	☐
(106) Heart or vascular trouble	☐	☐	(117) Neurological disorders: stroke, epilepsy, seizure, paralysis etc.	☐	☐	(128) Any other illness or injury	☐	☐	(174) Mental illness	☐	☐
(107) High or low blood pressure	☐	☐	(118) Psychological/psychiatric trouble of any sort	☐	☐	(129) Admission to hospital	☐	☐	(175) Diabetes	☐	☐
(108) Kidney stone or blood in urine	☐	☐	(119) Alcohol/drug/substance abuse	☐	☐	(130) Visit to medical practitioner since last medical examination	☐	☐	(176) Tuberculosis	☐	☐
(109) Diabetes, hormone disorder	☐	☐	(120) Attempted suicide	☐	☐	(131) Refusal of life insurance	☐	☐	(177) Allergy/asthma/eczema	☐	☐
(110) Stomach, liver or intestinal trouble	☐	☐	(121) Motion sickness requiring medication	☐	☐	(132) Refusal of flying licence	☐	☐	(178) Inherited disorders	☐	☐
(111) Deafness, ear disorder	☐	☐	(122) Anaemia / Sickle cell trait/ other blood disorders	☐	☐	(133) Medical rejection from or for military service	☐	☐	(179) Glaucoma	☐	☐
						(134) Award of pension or compensation for injury or illness	☐	☐	**Females only**		
									(150) Gynaecologicaltroubles, menstrual problems	☐	☐
									(151) Are you pregnant?	☐	☐

(30) Remarks:

Are there any changes since the last medical check? ☐ Yes ☐ No

(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 statement. I understand that if I have made any false or misleading statement in connection with this application, or fail to release the supporting medical information, the 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 Aeromedical Section and where necessary the Aeromedical Section of another State, 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 Authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times.

Date	Signature of applicant	Signature of AME / medical assessor	Examiner's Name and Address: **Tel:** **Fax:** **AME No.:**