

Medical Certificate Application form

I apply to the Director of Civil Aviation for a medical certificate, and hereby request a Medical Examiner to examine me for that purpose. I understand that I must pay the required Medical Certificate Application Fee of \$120.75 (including GST) as required by the Civil Aviation Fees and Charges Regulations 2012 **before** I attend an appointment with a Medical Examiner.

PAYMENT DETAILS

CAA Medical Examiner to complete

Receipt Number (attach confirmation):

Date Payment Made:

| | | | | | | | |
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| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
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CAA Medical Examiner to sight and verify confirmation

For more information on how to pay, see www.caa.govt.nz/medical

YOUR INFORMATION (to be completed by applicant)

Title: Mr Mrs Miss Ms _____

First Names:

Surname: (If changed recently, give previous surname in brackets & attach evidence)

Known As:

CAA Client ID:

Age:

Date of Birth: (DD/MM/YYYY)

| | | | | | | | |
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Gender: (please tick)

M F

Address for Service:

Civil Aviation Act, s8, requires applicants to provide an address for service (ie, a physical NZ address) and to promptly notify the Director of any changes.

City/Town:

Postcode:

| | | | | |
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Postal Address: (If different from Address for Service)

City/Town:

State:

Country:

Postcode:

| | | | | | | | |
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Phone No: (Business)

Phone No: (Private)

Mobile:

Email:

Certificate applied for:

Class 1 & 2 Class 2 Class 2 – No IFR Class 3

NZ Aviation document currently held:

ATPL CPL Private RPL ATC None Yet

Other or previous licences: Have you ever had a civil aviation licence or medical certificate issued before, either in New Zealand or from another authority? (Please give the year, country and licence type/number)

Employer:

Aero Club / Training Facility:

Occupation:

Aircraft types flown recently:

Hours you have flown:

Total:

Last 6 months:

General Practitioner name: (must be supplied)

General Practitioner Practice: (must be supplied)

MEDICAL HISTORY *Have you ever experienced any of the following: (please tick the correct answer)*

| | | | | | | | |
|------|---|-------------------------|-------------------------|---------------------|--|-------------------------|-------------------------|
| 1.1 | Eye or vision trouble | Y <input type="radio"/> | N <input type="radio"/> | 1.37 | Anxiety disorder/panic disorder | Y <input type="radio"/> | N <input type="radio"/> |
| 1.2 | Needed new glasses or contact lenses since last CAA medical examination | Y <input type="radio"/> | N <input type="radio"/> | 1.38 | Learning difficulty | Y <input type="radio"/> | N <input type="radio"/> |
| 1.3 | Eye or corneal surgery | Y <input type="radio"/> | N <input type="radio"/> | 1.39 | Attention deficit or hyperactivity disorder | Y <input type="radio"/> | N <input type="radio"/> |
| 1.4 | Hay fever | Y <input type="radio"/> | N <input type="radio"/> | 1.40 | Post traumatic stress disorder | Y <input type="radio"/> | N <input type="radio"/> |
| 1.5 | Middle ear infection | Y <input type="radio"/> | N <input type="radio"/> | 1.41 | Suicide attempt | Y <input type="radio"/> | N <input type="radio"/> |
| 1.6 | Sinusitis | Y <input type="radio"/> | N <input type="radio"/> | 1.42 | Any mental illness | Y <input type="radio"/> | N <input type="radio"/> |
| 1.7 | Hearing trouble | Y <input type="radio"/> | N <input type="radio"/> | 1.43 | Substance dependence or substance abuse | Y <input type="radio"/> | N <input type="radio"/> |
| 1.8 | Problems with balance | Y <input type="radio"/> | N <input type="radio"/> | 1.44 | Use of legal or illegal recreational drugs or substances | Y <input type="radio"/> | N <input type="radio"/> |
| 1.9 | Any other ears, nose & throat problems or surgery | Y <input type="radio"/> | N <input type="radio"/> | 1.45 | Alcohol dependence or abuse | Y <input type="radio"/> | N <input type="radio"/> |
| 1.10 | Asthma or wheezing | Y <input type="radio"/> | N <input type="radio"/> | 1.46 | Muscle, bone or joint injury | Y <input type="radio"/> | N <input type="radio"/> |
| 1.11 | Chronic cough | Y <input type="radio"/> | N <input type="radio"/> | 1.47 | Back pain, injury or 'back trouble' | Y <input type="radio"/> | N <input type="radio"/> |
| 1.12 | Any other lung problems | Y <input type="radio"/> | N <input type="radio"/> | 1.48 | Swollen or painful joints | Y <input type="radio"/> | N <input type="radio"/> |
| 1.13 | Any shortness of breath | Y <input type="radio"/> | N <input type="radio"/> | 1.49 | Suffered any pain severe enough to be disabling | Y <input type="radio"/> | N <input type="radio"/> |
| 1.14 | Pulmonary embolism or deep vein thrombosis | Y <input type="radio"/> | N <input type="radio"/> | 1.50 | Passed blood with or in urine or faeces | Y <input type="radio"/> | N <input type="radio"/> |
| 1.15 | Coughed or vomited blood | Y <input type="radio"/> | N <input type="radio"/> | 1.51 | Kidney, bladder or prostatic disease | Y <input type="radio"/> | N <input type="radio"/> |
| 1.16 | Any severe allergy | Y <input type="radio"/> | N <input type="radio"/> | 1.52 | Easy fatigue-ability or sleep in the day | Y <input type="radio"/> | N <input type="radio"/> |
| 1.17 | Heart problem | Y <input type="radio"/> | N <input type="radio"/> | 1.53 | Investigations for abnormal glucose tolerance, high blood sugar, or diabetes | Y <input type="radio"/> | N <input type="radio"/> |
| 1.18 | Vascular problem | Y <input type="radio"/> | N <input type="radio"/> | 1.54 | Medical Certificate for absence of 7 or more days from work or school | Y <input type="radio"/> | N <input type="radio"/> |
| 1.19 | Suffered any chest pain | Y <input type="radio"/> | N <input type="radio"/> | 1.55 | Rejection or premium loading for life or health insurance | Y <input type="radio"/> | N <input type="radio"/> |
| 1.20 | Rheumatic fever | Y <input type="radio"/> | N <input type="radio"/> | 1.56 | Rejection or retirement from employment on medical grounds | Y <input type="radio"/> | N <input type="radio"/> |
| 1.21 | High or low blood pressure | Y <input type="radio"/> | N <input type="radio"/> | 1.57 | Admission to hospital, psychiatric or in patient facility | Y <input type="radio"/> | N <input type="radio"/> |
| 1.22 | Severe abdominal pain | Y <input type="radio"/> | N <input type="radio"/> | 1.58 | Taken any type of medicine or alternative medicine for more than 2 weeks | Y <input type="radio"/> | N <input type="radio"/> |
| 1.23 | Hernia | Y <input type="radio"/> | N <input type="radio"/> | 1.59 | Had a positive laboratory test for HIV infection | Y <input type="radio"/> | N <input type="radio"/> |
| 1.24 | Oesophagus, stomach, liver, gall bladder or intestinal trouble | Y <input type="radio"/> | N <input type="radio"/> | 1.60 | Investigation for any disorder | Y <input type="radio"/> | N <input type="radio"/> |
| 1.25 | Diagnosed or treated for cancer, tumour, growth or malignancy (including skin cancer) | Y <input type="radio"/> | N <input type="radio"/> | 1.61 | Any major medical or surgical procedure | Y <input type="radio"/> | N <input type="radio"/> |
| 1.26 | Anaemia or blood disease | Y <input type="radio"/> | N <input type="radio"/> | 1.62 | Day surgery | Y <input type="radio"/> | N <input type="radio"/> |
| 1.27 | Headaches/migraines which have interfered in any way with daily living | Y <input type="radio"/> | N <input type="radio"/> | 1.63 | Any other illness, disability, debility, infirmity, treatment or surgery | Y <input type="radio"/> | N <input type="radio"/> |
| 1.28 | Headaches/migraines requiring medication | Y <input type="radio"/> | N <input type="radio"/> | FEMALES ONLY | | | |
| 1.29 | Dizziness or fainting spell | Y <input type="radio"/> | N <input type="radio"/> | 1.64 | Any troubling menstrual problems | Y <input type="radio"/> | N <input type="radio"/> |
| 1.30 | Unconsciousness for any reason | Y <input type="radio"/> | N <input type="radio"/> | 1.65 | Other gynaecological problem | Y <input type="radio"/> | N <input type="radio"/> |
| 1.31 | Head injury | Y <input type="radio"/> | N <input type="radio"/> | 1.66 | Any obstetric problem | Y <input type="radio"/> | N <input type="radio"/> |
| 1.32 | Seizures/fits | Y <input type="radio"/> | N <input type="radio"/> | 1.67 | Breast lump or other breast problem | Y <input type="radio"/> | N <input type="radio"/> |
| 1.33 | Stroke | Y <input type="radio"/> | N <input type="radio"/> | 1.68 | Pregnancy – Are you pregnant? | Y <input type="radio"/> | N <input type="radio"/> |
| 1.34 | Paralysis | Y <input type="radio"/> | N <input type="radio"/> | | | | |
| 1.35 | Any other neurological disorder | Y <input type="radio"/> | N <input type="radio"/> | | | | |
| 1.36 | Diagnosed depression | Y <input type="radio"/> | N <input type="radio"/> | | | | |

2. Have you ever had any medical certificate denied, suspended, or revoked within or outside of New Zealand? Yes No
3. Have you ever been convicted of an alcohol or drug-related offence, including a drink-driving offence, or is any action pending for such an offence? Yes No
4. Have you ever received any Notice under Section 271 or 27H of the Civil Aviation Act (suspension, restriction, endorsements, etc) during the period of the current or last medical certificate? Yes No

FAMILY HISTORY

5. Have any members of your family had vascular disease, hypertension, diabetes, heart disease, psychiatric disease or neurological disease? (If Yes, please mention below the name of the disease and the age when discovered) Yes No

| | |
|----------------------|----------------------|
| Mother: | Father: |
| <input type="text"/> | <input type="text"/> |
| Siblings: | Grandparents: |
| <input type="text"/> | <input type="text"/> |
| Other: | |
| <input type="text"/> | |

SMOKING

6. Have you ever smoked? Yes No
- If yes – In total, how many years have you smoked for? Average quantity smoked (Packs/week)
- Are you still smoking or have you smoked within the last 12 months? Yes No

ALCOHOL (LAST 12 MONTHS)

7. How often do you have a drink containing alcohol?
 Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week
8. How many drinks containing alcohol do you have on a typical day when you are drinking?
 1 or 2 3 or 4 5 or 6 7 to 9 10 or more
9. Total number of units per week?
10. How often do you have six or more drinks on one occasion?
 Never Less than monthly Monthly Weekly Daily or almost daily

11. Have you VISITED a health professional within the last 3 years? (If yes, explain below) Yes No
- | | | |
|----------------------|----------------------|----------------------|
| Date visited: | GP/Specialist: | Reason for visit: |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

12. Have you taken any MEDICATION in the past 3 years for two weeks or more? (If yes, explain below) Yes No
- | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|
| Name: | Dosage: | Purpose: | Date started: | Date finished: |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

If you have answered 'Yes' to any questions from 1-12, please provide all details of each instance (Please use extra pages or attach documents as required).

| | |
|----------------------|----------------------|
| Question No: | Details: |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

CONSENT

I consent to the disclosure to the Director and/or his delegate, of any medical or health information relating to me which is held by a registered medical practitioner, hospital or other organisation.

I consent to government agencies including the New Zealand Transport Agency and the Ministry of Justice disclosing to the Director information about any convictions I have or current charges against me.

I consent to the Civil Aviation Authority and the Director of Civil Aviation using information about me for any reasonable purpose:

- related to this medical certificate application, and/or
- related to the powers, duties and functions of the Civil Aviation Authority and the Director of Civil Aviation.

I consent to the Civil Aviation Authority and Director disclosing this information to any person who requires such information to carry out any function authorised by law.

I understand that the Civil Aviation Authority and Director may provide relevant medical information to other international jurisdictions in the interests of aviation safety.

ACKNOWLEDGMENT

I acknowledge and understand the following:

That I have obligations under the Civil Aviation Act 1990, in relation to –

1. the provision of information, for the purpose of obtaining a medical certificate. I understand that failing to comply with these obligations is an offence, and
2. advising a medical examiner or reporting to the Director if I become aware of, or suspect that there is any change in my medical condition or the existence of a previously undetected medical condition that may interfere with the safe exercise of the privileges to which my medical certificate relates, and
3. advising a medical examiner or reporting to the Director if I am charged with any alcohol or drug related offence, and
4. the making or causing to be made of any fraudulent, misleading, or intentionally false statement for the purpose of obtaining a medical certificate constitutes an offence under section 46B of the Civil Aviation Act 1990, and is subject, in the case of an individual, to imprisonment for a term not exceeding 12 months or to a fine not exceeding \$10,000, and
5. the failure to notify the Director of any change in medical condition or the existence of a previously undetected medical condition constitutes an offence under section 46C of the Civil Aviation Act 1990, and is subject, in the case of an individual, to imprisonment for a term not exceeding 12 months or to a fine not exceeding \$5,000.

I understand that if my Medical Examiner is unable to assess me as meeting the medical standards they may still seek to consider my application under the formal flexibility provisions of the legislation. If my Medical Examiner chooses that option, and I elect to proceed with the application, then I also understand that an Accredited Medical Conclusion (AMC) will be required. If that happens, I understand that:

- Work related to the AMC will be charged to me by CAA at a rate of \$284/hour (incl. GST) for all hours or part thereof over the first two hours, and that I am required to pay this;
- I can withdraw my medical certificate application at any time and will not incur any further AMC costs, but any costs (after the first two hours) incurred prior to withdrawing will remain payable;
- There can be no guarantee that an AMC will lead to the issue of a medical certificate, or an unrestricted medical certificate;
- I will be required to pay for any charges incurred on my AMC, as described above, whatever the final outcome of my medical certificate application; and
- I should not be directly charged for services relating to an AMC from anyone other than the CAA.

I have read this application form, familiarised myself with it and understand its contents, including the consent and acknowledgment in the above paragraphs. I confirm that all the information that I have entered onto this form is true and accurate in all respects:

Applicant's Signature:

Date: (DD/MM/YYYY)

I have explained this form to the applicant and confirm that he/she has signed it in my presence.

Medical Examiner's Signature:

Date: (DD/MM/YYYY)

Medical Examiner's Name and/or Stamp: