



(stamp/logo of the receiver)

APPLICATION FORM FOR A MEDICAL CERTIFICATE

MEDICAL IN CONFIDENCE

Complete this page fully and in block capitals - Refer to instructions pages for details

Form with 28 numbered sections for personal and medical information, including fields for name, birth, address, flight hours, and medical history.

General and medical history: Do you have, or have you ever had, any of the following? (Please tick).

If yes, give details in remarks section (30).

Table with 12 columns for various medical conditions (101-178) and 'FAMILY HISTORY OF:' (179-184), with 'YES' and 'NO' checkboxes.

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

(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...

Date Signature of applicant Signature of AME/(GMP)/ (medical assessor)

Remarks

**(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 statements. 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 licensing 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 AME and, where necessary, to the medical assessor of the my licensing authority, to the medical assessor of the competent authority of my AME and to relevant medical professionals for the purpose of completion of an aero-medical assessment or a secondary review, 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 licensing authority, providing that I or my physician may have access to them according to national law. Medical confidentiality will be respected at all times.

**NOTIFICATION OF DISCLOSURE OF PERSONAL DATA:** I hereby declare that I have been informed and I understand that the data contained in my medical certificate according to ARA.MED.130 may be electronically stored and made available to my AME in order to provide historical data required in MED.A.035(b)(2)(i)/(ii) and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of ARA.MED.150(c)(4).

Date .....

Signature of applicant .....

Signature of AME/(GMP)/ (medical assessor) .....