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|  | ***Bulgarian Civil Aviation Administration*****APPLICATION FORM FOR AN AVIATION MEDICAL CERTIFICATE** |

*COMPLETE THIS PAGE FULLY AND BLOCK CAPITALS – REFER TO INSTRUCTIONS PAGES FOR DETAILS*

 **MEDICAL IN CONFIDENCE**

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

Note: if revalidating at the same venue as last examination, tick only boxes relating to any medical/surgical/ophthalmic or other events or changes since last examined. If ‘no change, state this in

‘Remarks,.

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| (1) State of licence issue: | (2) Medical certificate applied for: class 1  class 2  LAPL  Others  class 3  C/C   |
| (3) Surname: | (4) Previous surname(s): | (12) Application Initial Revalidation/Renewal  |
| (5) Forenames: | (6) Date of birth: | (7) SexMale Female  | (13) Reference number: |
| (8) Place and country of birth: | (9) Nationality: | (14) Type of licence applied for: |
| (10) Permanent address:Country : Telephone e-mail  | (11) Postal address (if different)Country : Telephone No. : | (15) Occupation (principal) |
| (16) Employer |
| (17) Last medical examinationDate: Place: |
| (18) Aviation licence(s) held (type):Licence number: State of issue: | (19) Any Limitations on Licence/ Medical Certificate No  Yes Details: |
| (20) Have you ever had an aviation medical certificate denied, suspended orrevoked by any licensing authority?No  Yes  Date: Country: Details: | (21) Flight time hours total: | (22)Flight time hours since last medical: |
| (23) Aircraft class /type(s) currently flown: |
| (24) Any aviation accident or reported incident since last aero-medical examination?No  Yes  Date: Place:Details: | (25) Type of flying intended: |
| (26) Current flying activity: Single pilot  Multi pilot Current ATCO activity: ADI  APS  ACS  |
| (27) Do you drink alcohol? No  Yes, amount | (28) Do you currently use any medication?No  Yes  State drug, dose, date started and why: |
| (29) Do you smoke tobacco?  No, never  No, date stopped: Yes, state type and amount: |

 Yes No Yes No Yes No **Family history of:** Yes No

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| 101 Eye trouble/eye operation |  |  | 112 Nose, throat or speech disorder |  |  | 123 Malaria or other tropical disease |  |  | 170 Heart disease |  |  |
| 102 Spectacles and/or contact lenses ever worn |  |  | 113 Head injury or concussion |  |  | 124 A positive HIV test |  |  | 171 High blood pressure |  |  |
| 114 Frequent or severe headaches |  |  | 125 Sexually transmitted disease |  |  | 172 High cholesterol leve |  |  |
|  103 Spectacle/contact lens prescrip- tions change since last medical exam. |  |  | 115 Dizziness or fainting spells |  |  | 126 Sleep disorder/ apnoea |  |  | 173 Epilepsy |  |  |
| 116 Unconsciousness for any reason |  |  | 127 Musculoskeletal illness/ impairment |  |  | 174 Mental illness |  |  |
| 104 Hay fever, other allergy |  |  | 117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc |  |  | 128 Any other illness or injury |  |  | 175 Diabetes |  |  |
| 105 Asthma, lung disease |  |  | 129 Admission to hospital | 176 Tuberculosis |  |  |
| 106 Heart or vascular trouble |  |  | 118 Psychological/psychiatric trouble of any sort |  |  | 130 Visit to medical practitioner since last medical examination |  |  | 177 Allergy/asthma/eczema |  |  |
| 107 High or low blood pressure |  |  |  |  | 178 Inherited disorders |  |  |
| 108 Kidney stone or blood in urine |  |  | 119 Alcohol/drug/substance abuse |  |  | 131 Refusal of life insurance |  |  | 179 Glaucoma |  |  |
| 109 Diabetes, hormone disorder |  |  | 120 Attempted suicide |  |  | 132 Refusal of pilot/ATCO licence | **Females only:** |
| 110 Stomach, liver or intestinal trouble |  |  | 121 Motion sickness requiring medication |  |  | 133 Medical rejection from or for military service |  |  |
| 150 Gynaecological, menstrual problems |  |  |
| 111 Deafness, ear disorder |  |  | 122 Anaemia / Sickle cell trait/other blood disorders |  |  | 134 Award of pension or |  |  |
|  |  |  | compensation for injury or illness |  |  | 151 Are you pregnant? |  |  |
| (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 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.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 Medical Assessor of the Licensing Authority and where necessary to the Medical Asessor of another EASA Member 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 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.--------------------------------- ------------------------------------------------ -------------------------------Date Signature of applicant Signature of AME |