DIRECTORATE GENERAL "CIVIL AVIATION ADMINISTRATION"

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Issue 4 Rev 03/12.03.2026 AM Manual

COMPLETE THIS PAGE FULLY AND IN BLOCK CAPITALS

ЛИН _____

MEDICAL IN CONFIDENCE

(1) State of licence issue:	(2) Medical certificate applied for: Class 1 ☐ Class2 ☐ LAPL ☐ ATCO ☐ C/C ☐	
(3) Surname:	(4) Previous surname:	(12) Application for: Initial ☐ Revalidation / Renewal ☐
(5) Forenames:	(6) Date of birth: / (7) Sex: Male ☐ Female ☐	(13) MC №: / EAMR ID:
(8) Place and country of birth:	(9) Nationality:	(14) Type of licence applied for:
(10) Permanent address: Mobile: e-mail:	(11) Postal address (if diferent) Country : Phone :	(15) Occupation (principal): (16) Employer: (17) Last medical examination: Date: Completed: NO ☐ YES ☐ Place:

(18) Licence held (type): Licence No: State of issue:	(19) Any Limitation on Licence / Medical Certificate: NO ☐ YES ☐ Details:
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? NO☐ Y E S ☐ Date: Country: Details:	(21) Flight time hours total: / (22) Flight time hours since last medical: (23) Aircraft class / type(s), presently flown:
(24) Any aviation accident medical event whilst exercising the privileges of the licence since the last medical examination? NO ☐ YES ☐ Date: Place: Details:	(26) Current / intended ATC activity: ADI ☐ APS ☐ ACS ☐ ADV ☐ APP ☐ ACP ☐ (25) Current / intended pilot activity: Commercial ☐ Non-commercial ☐ Other ☐ Single ☐ Multi-pilot ☐
(27) Do you drink alcohol? ☐ NO ☐ YES, state average weekly amount Do you use drugs? ☐ NO ☐ YES, state the type	(28) Do you currently use any medication? NO ☐ YES ☐ State drug, dose, date started and why:
(29) Do you smoke tobacco? ☐ NO, never ☐N O , date stopped: ☐ YES, state type and amount:	

General medical history: Do you have, or have you ever had, any of the following? (Please tick a response for each question). If YES, give details in the remarks section (30).

	YES	NO		YES	NO		YES	NO	Family history of:	YES	NO
101 Eye trouble / Eye operation			112 Nose, throat or speech disorder			123 Malaria or other tropical disease			170 Heart or vascular disease		
102 Spectacles and/or contact lenses ever worm			113 Head injury or concussion			124 A positive HIV test			171 High blood pressure		
			114 Frequent or severe headaches			125 Sexually transited disease			172 High cholesterol level		
103 Spectacles/contact lenses prescriptions change last medical exam			115 Dizziness or fainting spells			126 Sleep disorder/apnea syndrome			173 Epilepsy		
			116 Unconsciousness for any reason			127 Musculoskeletal illness/impairment			174 Mental illness or suicide		
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 or mental health specialist 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 Misuse of psychoactive			131 Refusal of life insurance			179 Glaucoma		
109 Diabetes, hormone disorder			120 Attempted suicide or self-harm			132 Refusal of aviation licence					
110 Stomach, liver or intestinal trouble			121 Motion sickness requiring medication			133 Medical rejections from or for military service			**Female only:**		
111 Deafness, ear disorder			122 Anemia/Sickle cell trait/other blood disorders			134 Award of pension or compensation for injury or illness			150 Gynecological, menstrual problems		
									151 Are you pregnant?		

(30) **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.

I hereby declare that I have been informed and I understand that all information provided to my AME contained in this report and its attachments and all information which is provided to my licensing authority and that relates to me, may be released to the medical assessor of my licensing authority, other health professionals and medical administration staff as part of the aero-medical assessment process and to the medical assessor of the competent authority of my AME, recognising that these documents or electronically stored data are to be used for the completion of an aero-medical assessment and for oversight purposes, providing that I or my physician may have access to them in accordance with 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 in accordance with point ARA.MED.130, or point ATCO.AR.F.005 of Regulation (EU) 2015/340 if applicable, may be electronically stored and made available to my AME in order to provide historical data required in point MED.A.035(b)(2)(ii)/(iii) or, if applicable, points ATCO.MED.A.035(b)(2)(ii) or ATCO.MED.A.035(b)(2)(iii), and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of point ARA.MED.150(c)(4). **ATCO.MED.A.035(b)(2)(ii) или ATCO.MED.A.035(b)(2)(iii), както и на медицинските оценители на компетентните органи на държавите членки с цел улесняване прилагането на точка ARA.MED.150(c)(4).**

----------	----------	----------
Date	Signature of applicant	Signature of AME/OHMP/Medical assessor