

**REPUBLIC OF SLOVENIA**

**CIVIL AVIATION AGENCY**

**APPLICATION FORM FOR A MEDICAL CERTIFICATE**

Complete this page fully and in block capitals – Refer to instructions pages for details. **MEDICAL IN CONFIDENCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (1) State of licence issue: | (2) Medical certificate applied for: class 1 class 2 LAPL class 3 | | | | |
| (3) Surname: | (4) Previous surname(s): | | | (12) Application: Initial  Revalidation/Renewal | |
| (5) Forenames: | (6) Date of birth (dd/mm/yyyy): | | (7) Sex:  Male  Female | (13) Reference number: | |
| (8) Place and country of birth: | (9) Nationality: | | | (14) Type of licence applied for: | |
| (10) Permanent address: | (11) Postal address (if different): | | | (15) Occupation (principal): | |
| Country: |  | | | (16) Employer: | |
| Telephone No.:  Mobile No.:  e-mail: | Country:  Telephone No.: | | | (17) Last medical examination:  Date:  Place: | |
| (18) Licence(s) held (type):  Licence number:  State of issue: | | (19) Any limitations on Licence(s)/ Medical Certificate: No Yes  Details: | | | |
| (20) Have you ever had a medical certificate denied, suspended or revoked by any licensing authority?  No Yes Date: Country:  Details: | |
| (21) Flight time hours total:  hrs: n/a | | | (22) Flight time hours since last medical:  hrs: n/a |
|  | | (23) Aircraft class/type(s)presently flown:  n/a | | | |
| (24) Any aviation accident or reported incident since last medical examination?  No Yes Date: Place: | | (25) Type of flying intended: | | | |
| Details: | | (26) Present 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: | |  | | | |

**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).**

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

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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 |  |  | 113 Head injury or concussion |  |  | 124 A positive HIV test |  |  | 171 High blood pressure |  |  |
| lenses ever worn |  |  | 114 Frequent and or severe headaches |  |  | 125 Sexually transmitted disease |  |  | 172 High cholesterol level |  |  |
| 103 Spectacle/contact lens prescript- tions change since last medical examination |  |  | 115 Dizziness or fainting spells |  |  | 126 Sleep disorder/apnoea 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, |  |  | 128 Any other illness or injury |  |  | 175 Diabetes |  |  |
| 105 Asthma, lung disease |  |  | epilepsy, seizure, paralysis, etc. |  |  | 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 |  |  | 119 Alcohol/drug/substance abuse |  |  | 131 Refusal of life insurance |  |  | 178 Inherited disorders |  |  |
| 108 Kidney stone or blood in urine |  |  | 120 Attempted suicide or self-harm |  |  | 132 Refusal of flying licence |  |  | 179 Glaucoma |  |  |
| 109 Diabetes, hormone disorder |  |  | 121 Motion sickness requiring |  |  | 133 Medical rejection from or for |  |  | **Females only:** |  |  |
| 110 Stomach, liver or intestinal trouble |  |  | medication |  |  | military service |  |  | 150 Gynaecological, |  |  |
|  |  | 122 Anaemia / Sickle cell trait/other |  |  | 134 Award of pension or |  |  | menstrual problems |  |  |
| 111 Deafness, ear disorder |  |  | blood disorders |  |  | 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, 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 competen t authority of my AME and to relevant medical professionals for the purpose of completion o fan 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 DISLOSURE 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)(ii)/(iii) 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 / medical assessor | | | | | | | | | | | |

**INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FORM FOR A MEDICAL CERTIFICATE**

This application form and all attached report forms will be transmitted to the licensing authority. Medical confidentiality shall be respected at all times.

The applicant should personally complete, in full, all questions (sections) on the application form. Writing should be legible and in block capitals, using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any questions, a plain sheet of paper should be used, bearing the applicant’s name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the application form for a medical certificate.

Failure to complete the application form in full, or to write legibly, may result in non-acceptance of the application form. The making of false or misleading statements or the withholding of relevant information in respect of this application may result in criminal prosecution, denial of this application and/or withdrawal of any medical certificate(s) granted.

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| --- | --- |
| **1. LICENSING AUTHORITY:**  State name of country this application is to be forwarded to. | **18. LICENCE(S) HELD (TYPE):**  State type of licence(s) held. Enter licence number and State of issue.  If no licences are held, state ‘NONE’. |
| **2. MEDICAL CERTIFICATE APPLIED FOR:**  Tick appropriate box representing the type of medical certificate applied for, e.g.:  Class 1: Professional Pilot  Class 2: Private Pilot  Class 3: Air Traffic Controller  Class LAPL: Light Aircraft Pilot | **19. ANY LIMITATIONS ON THE LICENCE(S)/MEDICAL CERTIFICATE:**  Tick appropriate box and give details of any limitations on your licence(s)/medical certificate, e.g. vision, colour vision, safety pilot, etc. |
| **3. SURNAME:**  State surname/family name. | **20. MEDICAL CERTIFICATE DENIAL, SUSPENSION OR REVOCATION:**  Tick ‘YES’ box if you have ever had a medical certificate denied, suspended or revoked, even if only temporary.  If ‘YES’, state date (dd/mm/yyyy) and country where it occurred. |
| **4. PREVIOUS SURNAME(S):**  If your surname or family name has changed for any reason, state previous name(s). | **21. FLIGHT TIME TOTAL:**  State total number of hours flown. |
| **5. FORENAME(S):**  State first and middle names (maximum three). | **22. FLIGHT TIME SINCE LAST MEDICAL:**  State number of hours flown since your last medical examination, or, for ATCO’s tick n/a box. |
| **6. DATE OF BIRTH:**  Specify in order dd/mm/yyyy | **23. AIRCRAFT CLASS/TYPE(S) PRESENTLY FLOWN:**  State name of principal aircraft flown, e.g. Boeing 737, Cessna 150, Balloon, etc., or, for ATCO’s tick n/a box. |
| **7. SEX:**  Tick appropriate box. | **24. ANY AVIATION ACCIDENT OR REPORTED INCIDENT SINCE THE LAST MEDICAL EXAINATION:**  If ‘YES’ box ticked, state date (dd/mm/yyyy) and country of accident/incident. |
| **8. PLACE AND COUNTRY OF BIRTH:**  State town and country of birth. | **25. TYPE OF FLYING INTENDED:**  State whether airline, charter, single-pilot, commercial air transport, carrying passengers, agriculture, pleasure, etc., or, for ATCO’s tick n/a box. |
| **9. NATIONALITY:**  State name of country of citizenship. | **26. PRESENT FLYING ACTIVITY:**  Tick appropriate box to indicate whether you fly as the SOLE pilot or for ATCO’s whether you operate as tower, radar or other. |
| **10. PERMANENT ADDRESS:**  State permanent postal address and country. Enter telephone area code as well as telephone number. | **27. DO YOU DRINK ALCOHOL ?**  Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 litres of beer. |
| **11. POSTAL ADDRESS (IF DIFFERENT):**  If different from permanent address, state full current postal address including telephone number and area code.  If the same, enter ‘SAME’. | **28. DO YOU CURRENTLY USE ANY MEDICATION?**  If ‘YES’, give full details - name, how much you take and when, etc.  Include any non-prescription medication. |
| **12. APPLICATION:**  Tick appropriate box. | **29. DO YOU SMOKE TOBACCO?**  Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (e.g. 2 cigars daily; pipe – 1 oz. weekly) |
| **13. REFERENCE NUMBER:**  State reference number allocated to you by the licensing authority  Initial applicants enter ‘NONE’ | **GENERAL AND MEDICAL HISTORY**  All items under this heading from number 101 to 179 inclusive should have the answer ‘YES’ or ‘NO’ ticked.  You should tick ‘YES’ if you have ever had the condition in your life and describe the condition and approximate date in the (30) remarks section.  All questions asked are medically important even though this may not be readily apparent.  Items numbered 170 to 179 relate to immediate family history, whereas items numbered 150 to 151 should be answered by female applicants only.  If information has been reported on a previous application form for a medical certificate and there has been no change in your condition, you may state ‘Previously reported; no change since’. However, you should still tick ‘YES’ to the condition.  Do not report occasional common illnesses such as colds. |
| **14. TYPE OF LICENCE APPLIED FOR:**  State type of licence applied for from the following list:  Aeroplane Transport Pilot Licence (**ATPL**)  Multi-Pilot Licence (**MPL**)  Commercial Pilot Licence/Instrument Rating (**CPL/IR**)  Commercial Pilot Licence (**CPL**)  Air Traffic Controller Licence (**ATCO**)  Private Pilot Licence/Instrument Rating (**PPL/IR**)  Private Pilot Licence (**PPL**)  Sailplane Pilot Licence (**SPL**)  Balloon Pilot Licence (**BPL**)  Light Aircraft Pilot Licence (**LAPL**)  And whether Fixed Wing / Rotary Wing / Both  Other – Please specify |
| **15. OCCUPATION (PRINCIPAL):**  Indicate your principal employment. | **31. DECLARATION AND CONSENT TO OBTAINING AND RELEASING INFORMATION:**  Do not sign or date these declarations until indicated to do so by the AME/GMP who will act as witness and sign accordingly |
| **16. EMPLOYER:**  If principal occupation is pilot, then state employer’s name or if self-employed, state ‘self’. |
| **17. LAST APPLICATION FOR A MEDICAL CERTIFICATE:**  State date (day, month, year) and place (town, country)  Initial applicants state ‘NONE’. | **.** |