

CAA/PL/P/19

# Civil Aviation Authority of Sri Lanka

How to obtain a Medical Certificate  
Medical Examination Procedure



1. Visit Civil Aviation Authority of Sri Lanka (CAASL) at, 152/1, Minuwangoda Road, Katunayake on any working day (Monday to Friday) during working hours, before 3.00 pm.
2. Submit perfected Medical application form (CAA/PL/E/01) collected or downloaded from our web site ([www.caa.lk](http://www.caa.lk)).
3. Initial fee for medical evaluation is Rs. 6494.60.
4. Renewal fee for medical evaluation is Rs. 3883.80.
5. Next collect your medical prescription addressed to the hospital opted by you. The prescription given for investigations will not be reissued. It is your responsibility to keep it safe until you produce it before the Designated Hospital. **If the original is lost, a duplicate can be obtained by paying a fee according to the fee schedule.**
6. The prescription shall be submitted to the specified counter of below mentioned designated Hospitals and complete all medical tests through the said counter.

Designated Hospitals are;

- I. **Inquiries Counter, Durdans Hospital**, No.03, Alfred Place Colombo 03
- II. **Wellness Centre, Asiri Surgical Hospital**, Kirimandala Mw, Colombo 05
- III. **Health Check Department, Lanka Hospital**, Elvitigala Mawatha, Colombo 5
- IV. **Health Check Coordinator, Hemas Hospital**, No. 389, Negombo Rd, Wattala.
- V. **Lifeline health Screening Centre, The Central Hospital**, No. 114, Norris Canal Rd, Colombo10.
- VI. **Serene Centre, Nawaloka Hospital**, 23, Deshamanya H K Dharmadasa Mw, Colombo 02.
- VII. **Cooperate Counter, Nawaloka Hospital**, 169, Colombo Road, Negombo.

(See annex 1 for list of designated Consultants)

7. The reports will be delivered by the designated hospitals to the Aeromedical Centre directly, reports will not be accepted by hand from the client.
8. **Three days** after completion of your final test, contact Aero Medical Centre to obtain an appointment to meet the doctor.
9. **Please note, the appointment for the initial medical assessment will be given only after all requested investigation reports are received at the Aeromedical Centre.**
10. Present yourself for the medical examination on given date and time. If you unable to present for the given date, kindly inform us at least 24 hours prior. Fresh appointment will be given according to the availability of slots.
11. Contact number of Aero Medical Centre **0112358974**
12. We conduct Medical examinations Monday to Friday working days from 10.30 to 12.30hrs.
13. Initial Medical Certificates are issued to Personal Licensing Section only after Medical Assessor's certification.
14. More information contact 0112358974 (Aero Medical Centre).  
Office Working Hours: 0830 hrs. – 1615 hrs.

## Annex 01

### List of Consultants designated by CAASL to Conduct Medical Investigations/Tests/Assessments under Designated Hospitals

Designated Hospital	Investigation	Designated Consultant/s
Asiri Surgical Hospital, Colombo 05	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. Mohan Jayathilake or Dr. J B Jayawardena
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. Mohan Jayathilake or Dr. J B Jayawardena
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. Mohan Jayathilake or Dr. J B Jayawardena
	4. Ophthalmology	4. Examine and report by Dr. Dinesh De Silva or Dr. Shiranthi Perera
Durdans Hospital, Colombo 03	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena or Dr Pandula Athauda-arachchi
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena or Dr Pandula Athauda-arachchi
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena or Dr Pandula Athauda-arachchi
	4. Ophthalmology	4. Examine and report by -----
	5. Stress ECHO Cardiogram	5. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena or Dr Pandula Athauda-arachchi
Lanka Hospital, Colombo 05	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena
	4. Ophthalmology	4. Examine and report by Dr. Shiranthi Perera
	5. Stress ECHO Cardiogram	5. Examine and report by Consultant Cardiologist Dr. P N Thenabadu or Dr. S W Shantharaj or Dr. Neomalie Amarasena or Dr. J B Jayawardena

Hemas Hospital, Wattala	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. Nimali Fernando or Dr. W S Shantharaj or Dr. Kishan De Silva
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. Nimali Fernando or Dr. W S Shantharaj or Dr. Kishan De Silva
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. Nimali Fernando or Dr. W S Shantharaj or Dr. Kishan De Silva
	4. Ophthalmology	4. Examine and report by Dr. Lalith Mallikarachchi or Dr. K A Salvin
Central Hospital Ltd, Colombo 10.	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. Kishan De Silva or Dr. W S Shantharaj
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. Kishan De Silva or Dr. W S Shantharaj
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. Kishan De Silva or Dr. W S Shantharaj
	4. Ophthalmology	4. Examine and report by Consultant Ophthalmologist Dr. Rangika Gunaratne or Dr. Dinesh De Silva
	5. Stress ECHO Cardiogram	5. Examine and report by Consultant Cardiologist Dr. Kishan De Silva or Dr. W S Shantharaj

Nawaloka Hospital, Colombo 02.	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. Mohan Rajakaruna or Dr. W S Santharaj or Dr. P N Thenabadu or Dr. Prakash Priyadarshan or Dr. Wasanthi Ratnayake
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. Mohan Rajakaruna or Dr. W S Santharaj or Dr. P N Thenabadu or Dr. Prakash Priyadarshan or Dr. Wasanthi Ratnayake
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. Mohan Rajakaruna, or Dr. W S Santharaj or Dr. P N Thenabadu or Dr. Prakash Priyadarshan or Dr. Wasanthi Ratnayake
	4. Ophthalmology	4. Examine and report by Consultant Ophthalmologist Dr. K A Salvin or Dr. Kusum Ratnayaka or Dr. Muditha Kulathunga
	5. Stress ECHO Cardiogram	5. Examine and report by Consultant Cardiologist Dr. Mohan Rajakaruna or Dr. W S Santharaj or Dr. P N Thenabadu or Dr. Prakash Priyadarshan or Dr. Wasanthi Ratnayake
	1. ENT	6. Examine and report by Consultant ENT Surgeon Dr M T D Lakshan
	6. Endocrinology	7. Examine and report by Consultant Endocrinologist Dr. Uditha Bulugahapitiya or Dr. Chaminda Garusinghe or Dr. Manilka Sumanathilaka

Nawaloka Hospital, Negombo.	1. Electrocardiogram	1. Examine and report by Consultant Cardiologist Dr. Taniya Perera or Dr. Mervin Fernando or Dr. Anidu Pathirana or Dr. Nimali Fernando or Dr. Disna Amaratuga
	2. ECHO cardiogram	2. Examine and report by Consultant Cardiologist Dr. Taniya Perera or Dr. Mervin Fernando or Dr. Anidu Pathirana or Dr. Nimali Fernando or Dr. Disna Amaratuga
	3. Stress ECG	3. Examine and report by Consultant Cardiologist Dr. Taniya Perera or Dr. Mervin Fernando or Dr. Anidu Pathirana or Dr. Nimali Fernando or Dr. Disna Amaratuga
	4. Ophthalmology	4. Examine and report by Consultant Ophthalmologist Dr. Wathsala Priyadarshani or Dr. Nihal Ganegoda or Dr. Wathsala Gunasekara.
	5. Stress ECHO Cardiogram	5. Examine and report by Consultant Cardiologist Dr. Taniya Perera or Dr. Mervin Fernando or Dr. Anidu Pathirana or Dr. Nimali Fernando

FORM CAA/PL/E/01



**CIVIL AVIATION AUTHORITY OF SRI LANKA**  
**MEDICAL EXAMINATION FORM FOR AVIATION LICENCES**

Receipt  
No

MEDICAL IN CONFIDENCE

(1) Full Name:					
(2) Initial with surname:	(3) Date of birth:	(4) Age:	(5) Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	(6) Application Initial <input type="checkbox"/> Renewal <input type="checkbox"/> Revalidation <input type="checkbox"/>	
(7) Class of medical certificate applied for I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/>	(8) Any Limitations on previous Licence / Medical Certificate No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Details :		(9) Type of licence applied for:		
(10) Place and country of birth:	(11) Nationality:	(12) Occupation (principal)			
(13) Permanent address:  Telephone No:  Mobile No:  E-Mail: @	(14) Employer:  (16) National Identity Card No:  Passport No:	(15) Date of licence expire: Date: Licensing system file number:  (17) Aviation licence(s) held (type):  Licence number:			
(18) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with AME No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ Place: _____ If Yes :- Details:- (reason)		(19) Total flight time hours:	(20) Flight time hours since last medical:	(21) Aircraft presently flown:-	
(22) Any air craft accident or reported incident since last Medical:- No <input type="checkbox"/> Yes <input type="checkbox"/> Date:- _____ Place:- _____ If yes, details:-		(23) Type of flying intended:  (24) Present flying activity Single pilot <input type="checkbox"/> Multi pilot <input type="checkbox"/>			
(25) Do you drink alcohol – state average weekly intake in liters:	(26) Have you taken any medication for longer than two weeks after the last Medical Examination? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, state drug, dose, date started and why?				
(27) Do you smoke tobacco? Never <input type="checkbox"/> No <input type="checkbox"/> Date stopped: Yes <input type="checkbox"/> State type, amount & number of years:					

**28) General and medical history:** Do you have, or have you ever had, any of the following? YES or NO (or as indicated) must be ticked after each question. Elaborate YES answers in the remarks section.

	Yes	No		Yes	No		Yes	No		Yes	No
(101) Eye trouble/eye operation			(112) Nose, throat or speech disorder			(123) Malaria or other tropical disease			<b>Family history of:</b>		
(102) Spectacles and / or contact lenses ever worn			(113) Head injury or concussion			(124) A positive HIV test			(170) Heart disease		
(103) Spectacle / contact lens prescriptions /change since last medical exam			(114) Frequent or severe headaches			(125) Sexually transmitted disease			(171) High blood pressure		
(104) Hay fever, other allergy			(115) Dizziness or fainting spells			(126) Admission to hospital			(172) High cholesterol level		
(105) Asthma, lung disease			(116) Unconsciousness for any reason			(127) Any other illness or injury			(173)Epilepsy		
(106) Heart or vascular trouble			(117) Neurological disorders; stroke, epilepsy, seizure paralysis, etc			(128) Visit to medical practitioner since last medical examination			(174) Mental illness		
(107) High or low blood pressure			(118) Psychological / psychiatric trouble of any sort			(129) Refusal of life insurance			(175) Diabetes		
									(176) Tuberculosis		
(108) Kidney stone or blood in urine			(119) Alcohol/ drug /substance abuse			(130) Refusal of flying licence			(177) Allergy/asthma		
									(178) Inherited disorders		
(109) Diabetes, hormon disorder			(120) Attempted suicide			(131) Do you hold a medical certification from any other CAA			(179) Glaucoma		
(110) Stomach, liver or intestinal trouble			(121) Motion sickness requiring medication			(132) Medical rejection from or for military service					
									<b>Females only:</b>		
(111) Deafness, ear disorder			(122) Anaemia/ Sickle cell trait/ other blood disorders			(133) Award of pension or compensation for injury or illness			(150) Gynecological, menstrual		
									(151) Are you pregnant?		

**Remarks:** If previously reported and no change since, so state.

(29) Declaration: I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. I understand that if I have made any false or misleading statement in connection with this application, or fail to release the supporting medical information; the 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. Medical confidentiality will be respected at all times.

.....  
Date

.....  
Signature of applicant

.....  
Signature (Witness)

**INSTRUCTION PAGE FOR COMPLETION OF THE APPLICATION FORM**  
**FOR AN AVIATION MEDICAL CERTIFICATE**

This Application Form, all attached Report Forms and Reports are required in accordance with ICAO instruction and will be transmitted to the Aero Medical Section. Medical confidentiality shall be respected at all times.

The Applicant must personally complete in full all questions (boxes) on the Application Form. Writing must be in **Block Capitals** using a ball-point pen and be legible. Exert sufficient pressure to make legible copies. If more space is required to answer any question, use a plain sheet of paper bearing the application form.

**NOTICE:** Failure to complete the application form in full or to write legibly will 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.

1. Full Name: State your full name.	16 State your National Identity Card Number. If Foreigner state your Passport Number.
2. Initial with surname: State your surname with initial.	17. Aviation licence held: State type of licences. .Enter licence number. If no licences are held, state 'NONE'.
3. Date of birth: Specify in order Day (DD), Month (MM), Year (YYYY) in numerals. E.g. 22-08-2008.	18. Medical Certificate denial or revocation: Tick 'YES' box if you have ever had a medical certificate denied or revoked even if only temporary. State date.
4. Age: State your age last birthday.	19. Total flight time hours: State total number of hours flown.
5. Sex: Tick appropriate box.	20. Flight time hours since last medical: State number of hours flown since your last medical examination.
6. Application: Tick appropriate box.	21. Aircraft presently flown: State name of principal aircraft flown. e.g. Boeing 737 etc.
7. Class of medical certificate : Tick appropriate box. Class 1 : Airline Transport Pilot Licences – Aeroplane, helicopter and power- lift Commercial Pilot Licences – Aeroplane, airship, helicopter and power- lift Class 2 : Private Pilot – flight navigator, licences, glider pilot licences, free balloon pilot licences Class 3 : Air Traffic Controller	22. Aircraft Accident/Incident: If 'YES' box ticked. State Date and Country of incident.
8. Any Limitations on the Licence / Medical Certificate: Tick appropriate box and give details of any limitations on your licences/medical certificates, e.g. vision, safety pilot etc	23. Type of flying intended: State whether airline, charter, single-pilot commercial air transport carrying passengers, agriculture, pleasure, etc.

<p>9. Type of licence applied for( Or intended):  State type of licence applied for from the following list:  Airline Transport Pilot Licence  Commercial Pilot Licence  Privet Pilot Licence/ Instrument Rating  Student Pilot  And whether Fixed Wing / Rotary Wing / Both  Air Traffic</p>	<p>24. Present flying activity:  Tick appropriate box to indicate whether you fly as the  SOLE pilot or not.</p>
<p>10. Place and country of birth:  State Town and Country of birth.</p>	<p>25. Do you drink alcohol:  Tick appropriate box. If ‘YES’, state weekly alcohol  consumption e.g. 2 liters beer.</p>
<p>11. Nationality:  State name of country of Citizenship.</p>	<p>26. Do you currently use any medication:  If yes, give full details – name, how much you take  and when, etc. Include any non- prescription  medication.</p>
<p>12. Occupation (principal)  State Captain/ First Officer/ Cadet Pilot / None etc.</p>	<p>27. Do you smoke tobacco:  Tick appropriate box. Current smokers state type  (cigarettes, cigars, pipe) and amount. e. g. 2 cigars  daily.</p>
<p>13. Permanent address:  State permanent postal address and telephone number.</p>	<p>28.General and medical history:  All items under this heading from number 101 to 179  inclusive must have the answer ‘YES” or ‘NO’ ticked.  You must tick ‘YES’ if you have ever had the condition  in your life describe the condition and approximate date  in the REMARKS box. 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 must be answered by female applicants only. If  information has been reported on a previous application  form and there has been no change since. However, you  must still tick ‘YES’ to the condition. Do not report  occasional common illnesses such as colds.</p>
<p>14. Employer  If principal occupation is pilot, then state employer’s name</p>	<p>29. Declaration and consent to obtaining and releasing  information:  Do not sign or date these declarations until indicated to do so by  the medical examiner who will act as witness and sign  accordingly.</p>
<p>15. Date of licence expire:  State date (day, month, year).  Initial applicants state ‘NONE’.  Licence system file number:  State your online file number.</p>	