FORM CAA/AMS/02

CIVIL AVIATION AUTHORITY OF SRI LANKA

Receipt No……
Fees Paid……

MEDICAL EXAMINATION FORM

MEDICAL IN CONFIDENCE

(1) Full Name:				
(2) Initial with surname:	(3) Date of birth:	(4) Age:	(5) Sex Male ☐ Female ☐	(6) Single ☐ Married ☐ Divorced ☐
(7) Class of medical certificate applied for I ☐ II ☐ III ☐	(8) Any Limitations on previous Licence / Medical Certificate No ☐ Yes ☐ N/A ☐ Details :			(9) Application Initial ☐ Renewal ☐ Revalidation ☐
(10) Place and country of birth:	(11) Nationality:	(12) Type of licence applied for:		
(13) Permanent address: Telephone No: Mobile No: E-Mail: @	(14) Employer: (17)National Identity Card No: Passport No:	(15) Occupation/Designation (16) Date of licence/Medical expire: Date: (18) Aviation licence(s) held (type): Licence number:		
(19) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with AME No ☐ Yes ☐ Date: Place: If Yes :- Details:- (reason)		(20) Total flight time hours:	(21) Flight time hours since last medical:	
		(22) Aircraft presently flown:-		
(23) Any air craft accident or reported incident since last Medical:- No ☐ Yes ☐ Date:- Place:- If yes, details:-		(24) Type of flying intended: Present flying activity Single pilot ☐ Multi pilot ☐		
(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 ☐ No ☐ If YES, state drug, dose, date started and why?			
(27) Do you smoke tobacco? Never ☐ No ☐ Date stopped: Yes ☐ 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			**Family history of:**		
(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					
									Females only:		
(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.

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Date	Signature of applicant	Signature (Witness)