



# MEDICAL CERTIFICATE APPLICATION

## INSTRUCTIONS

All responses in this application must be typed. Complete instructions are on page 4.

### A. APPLICANT INFORMATION

1. Class of Medical Certificate Applied for: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
2. Name (Last, First, Middle):		
3. PEL Number:	4. Citizenship:	
5a. Address (Number and Street):	5c. Country and Postal Code:	
5b. City and State/Province:	5d. Telephone No. & Email :	
6. Date of Birth:	7. Hair:	8. Eyes:
9. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
10. Types of licences you currently hold:		
<input type="checkbox"/> None	<input type="checkbox"/> ATC	<input type="checkbox"/> Flight Instructor
<input type="checkbox"/> Airline Transport	<input type="checkbox"/> Flight Engineer	<input type="checkbox"/> Private
<input type="checkbox"/> Commercial Pilot	<input type="checkbox"/> Remote Pilot	<input type="checkbox"/> Student Pilot Authorisation
<input type="checkbox"/> Multi-crew Pilot	<input type="checkbox"/> Cabin Crew	<input type="checkbox"/> Balloon
		<input type="checkbox"/> Glider
		<input type="checkbox"/> Other _____
11. Occupation:	12. Employer (Name and Telephone Number):	
13. Has your Airman Medical Certificate ever been denied, suspended, or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date		
14. Total Pilot Time (Civilian only): To date _____ Past 6 months _____		
15. Date of last medical application: <input type="checkbox"/> No prior application		
16. Do you currently use any medication (prescription or non-prescription)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list medication(s) used and indicate whether previously reported.		<b>Previously Reported</b>
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Do you ever use near-vision contact lenses when flying? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### B. MEDICAL HISTORY

Answer yes or no for every condition listed below. In Item 18c, Explanations, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if you reported the

18a. Have you ever been diagnosed with or had, or do you presently have, any of the following?

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	a. Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	b. Dizziness or fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	c. Unconsciousness for any reason	<input type="checkbox"/>	<input type="checkbox"/>	d. Eye or vision trouble except glasses
<input type="checkbox"/>	<input type="checkbox"/>	e. Hay fever or allergy	<input type="checkbox"/>	<input type="checkbox"/>	f. Asthma or lung disease
<input type="checkbox"/>	<input type="checkbox"/>	g. Heart or vascular trouble	<input type="checkbox"/>	<input type="checkbox"/>	h. High or low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	i. Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	j. Kidney stones or blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	k. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	l. Neurological disorders, epilepsy, seizures, stroke, paralysis, etc.
<input type="checkbox"/>	<input type="checkbox"/>	m. Mental disorders of any sort – anxiety, depression, etc.	<input type="checkbox"/>	<input type="checkbox"/>	n. Substance abuse or dependence; failed a drug test or used illegal substance(s)
<input type="checkbox"/>	<input type="checkbox"/>	o. Alcohol abuse or dependence; failed an alcohol test	<input type="checkbox"/>	<input type="checkbox"/>	p. Suicide attempt
<input type="checkbox"/>	<input type="checkbox"/>	q. Motion sickness medication required	<input type="checkbox"/>	<input type="checkbox"/>	r. Military medical discharge
<input type="checkbox"/>	<input type="checkbox"/>	s. Medical rejection by military service	<input type="checkbox"/>	<input type="checkbox"/>	t. Rejection for life or health insurance
<input type="checkbox"/>	<input type="checkbox"/>	u. Admission to hospital	<input type="checkbox"/>	<input type="checkbox"/>	v. Other illness, disability or surgery
<input type="checkbox"/>	<input type="checkbox"/>	w. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	x. High blood pressure

18b. Family medical history: Do any of the following pertain to your family's medical history?

<input type="checkbox"/>	<input type="checkbox"/>	y. Inherited disorders	<input type="checkbox"/>	<input type="checkbox"/>	z. High cholesterol levels
<input type="checkbox"/>	<input type="checkbox"/>	aa. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	bb. Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	cc. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	dd. Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	ee. Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	ff. Allergies/asthma/eczema

18c. Explanations (see instructions page):

**C. CONVICTION AND/OR ADMINISTRATIVE ACTION HISTORY** (see instructions page):

19a. Have you ever had (1) any convictions involving driving, flying, or operating as an airman while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) any convictions or administrative actions involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving or airman privileges or which resulted in attendance at an educational or rehabilitation program?  Yes  No

19b. Have you ever had any non-traffic convictions (misdemeanours or felonies)?  Yes  No

19c. Explanations (see instructions page):

**FOR CAA-B USE**  
Review Action Codes

20. Have you visited a health professional within the last 3 years?  Yes (explain below)  No (see instructions page)

Date	Name, address and type of health professional consulted	Reason

21. I hereby certify that all statements and answers provided by me on this application are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any Civil Aviation Authority Bahamas Act Section 41 (4) licence and certificate to me.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

**FOR MEDICAL EXAMINER USE ONLY**

**D. REPORT OF MEDICAL EXAMINATION**

Any falsification of this examination is punishable by law. The original copy of the medical examination must be typed.

22. Height (in) \_\_\_\_\_ 23. Weight (lb) \_\_\_\_\_ 24. Statement of Demonstrated Ability (SODA)  Yes  No Defect noted: \_\_\_\_\_ 25. SODA serial number \_\_\_\_\_

Check the appropriate column for each	Normal	Abnormal	Check the appropriate column for each	Normal	Abnormal
26. Head, face, neck and scalp	<input type="checkbox"/>	<input type="checkbox"/>	27. Nose	<input type="checkbox"/>	<input type="checkbox"/>
28. Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	29. Mouth and throat	<input type="checkbox"/>	<input type="checkbox"/>
30. Ears, general (internal and external canals, hearing under item 50)	<input type="checkbox"/>	<input type="checkbox"/>	31. Ear drums (perforation)	<input type="checkbox"/>	<input type="checkbox"/>
32. Eyes, general (vision under item 51)	<input type="checkbox"/>	<input type="checkbox"/>	33. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>
34. Pupils (equality and reaction)	<input type="checkbox"/>	<input type="checkbox"/>	35. Ocular motility (associated parallel movement, nystagmus)	<input type="checkbox"/>	<input type="checkbox"/>
36. Lungs and chest (not including breast examination)	<input type="checkbox"/>	<input type="checkbox"/>	37. Heart (precordial activity, rhythm, sounds and murmurs)	<input type="checkbox"/>	<input type="checkbox"/>
38. Vascular system (pulse, amplitude and character, arms, legs, others)	<input type="checkbox"/>	<input type="checkbox"/>	39. Abdomen and viscera (including hernia)	<input type="checkbox"/>	<input type="checkbox"/>
40. Anus (not including digital examination)	<input type="checkbox"/>	<input type="checkbox"/>	41. Skin	<input type="checkbox"/>	<input type="checkbox"/>
42. G-U system (not including pelvic examination)	<input type="checkbox"/>	<input type="checkbox"/>	43. Upper and lower extremities (strength and range of motion)	<input type="checkbox"/>	<input type="checkbox"/>
44. Spine, other musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	45. Identifying body marks, scars, tattoos (size and location)	<input type="checkbox"/>	<input type="checkbox"/>
46. Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	47. Neurologic (tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
48. Psychiatric (appearance, behaviour, mood, communication and memory)	<input type="checkbox"/>	<input type="checkbox"/>	49. General systemic	<input type="checkbox"/>	<input type="checkbox"/>

Note: Describe every abnormality in detail in Item 57. Enter the applicable item number before each comment. Use additional sheets if necessary and attach to this form.

### 50. Hearing

Conversational voice test at 2 metres <input type="checkbox"/> Pass <input type="checkbox"/> Fail					Audiometric speech discrimination score:				
<b>Right Ear (Audiometer threshold in decibels)</b>					<b>Left Ear (Audiometer threshold in decibels)</b>				
500	1000	2000	3000	4000	500	1000	2000	3000	4000

### 51. Vision

<b>Distant vision</b>		<b>Near vision</b>		<b>Intermediate vision</b>		<b>Colour perception</b>		
Right 20/ Left 20/ Both 20/	<b>Near Vision:</b> Corrected to 20/ Corrected to 20/ Corrected to 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Fail		<input type="checkbox"/> Pass <input type="checkbox"/> Fail		<input type="checkbox"/> Pass <input type="checkbox"/> Fail		
Field of vision: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Heterophoria 20' (prism dioptres):		Esophoria	Exophoria	Right Hyperphoria	Left Hyperphoria	
52. Blood pressure: Systolic Diastolic (sitting, mm of mercury)		53. Pulse (resting):		54. Urinalysis (if abnormal, give results) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Albumin	Sugar	55. ECG date

56. Sleep Apnoea:

57. Other tests given:

57. Comments on history and findings: The aviation medical examiner (AME) shall comment on all "yes" answers in the medical history section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc., to this report before mailing.)	For CAA-B Use
	Pathology Codes
	Coded By

Significant medical history?  Yes  No      Abnormal physical findings?  Yes  No      Clerical Reject

58. Action taken  
 Civil Aviation Authority Bahamas Medical Certificate issued  
 Civil Aviation Authority Bahamas Medical Certificate denied. Notice of Denial of Medical Certificate issued (copy attached)  
 Civil Aviation Authority Bahamas deferral letter issued (further evaluation necessary).

59. Disqualifying defects (list by item number):

60. I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.

Date of examination:	AME's name:	AME's signature:
AME's address:      Number/street:      City:	AME's designation number:	
State:      Country:      Postal code:	AME's telephone:	

## APPLICATION FORM FOR MEDICAL CERTIFICATE

### Instructions for Completing Form # PEL\_MDL001

#### Notes:

- (1) Applicant must complete numbers 1 through 21 of the application (type only).
- (2) Intentional falsification may result in criminal prosecution. Intentional falsification may also result in suspension or revocation of all airman, ground instructor, medical certificates, and ratings held by the applicant, as well as denial of this application for medical certification.

1. **Class of medical certificate applied for.** Check the appropriate box for the class of medical certificate for which you are making application.
2. **Name.** Enter your full name. If your name has changed for any reason, enter your current name and list any former name(s) in Item 18c, Explanations. All applicants without a middle name or initial should enter "NMN" or "NONE." Nicknames and abbreviated names must not be used.
3. **PEL number.** Enter CAA-B issued PEL number.
4. **Citizenship.** Enter the name of the country of which you are a citizen.
5. **5a-c. Address.** Enter your permanent mailing address, country, and complete postal code. **5d. Telephone number & Email.** Enter your complete telephone number and email address.
6. **Date of birth.** Enter your date of birth in m-mm-yyyy format (e.g., 31 Jan 1983).
7. **Hair.** Enter the colour of your hair as brown, black, blonde, grey, or red. If bald, enter "bald." Do not abbreviate.
8. **Eyes.** Enter the colour of your eyes as brown, blue, hazel, grey, or green. Do not abbreviate.
9. **Gender.** Select Male or Female.
10. **Types of licences you currently hold.** Check the applicable box(es). If you check "Other," provide the name of the licence.
11. **Occupation.** Indicate major employment. Enter "Pilot" only if you gain your livelihood by flying.
12. **Employer.** Provide your employer's full name and telephone number. If self-employed, enter "self-employed."
13. **Has your airman medical certificate ever been denied, suspended, or revoked?** Check yes or no. If yes, provide the date in dd-mm-yyyy format (e.g., 31 Jan 2013)
14. **Total pilot time.** Enter the total number of *civilian* flight hours to date and in the 6-month period immediately preceding the date of this application. Indicate whether the hours are logged or estimated (abbreviate as Log. or Est.).
15. **Date of last CAA-B medical application.** Enter the date of your last medical application in dd-mm-yyyy format (e.g., 31-Jan-2013). If none, enter "none."
16. **Do you currently use any medication (prescription or non-prescription)?** Check Yes or No. If yes, give the name of all medications and indicate if they were listed in a previous CAA-B medical examination. If more space is required, use a plain sheet of paper to record the information and then sign and date the paper.
17. **Do you ever use near-vision contact lenses when flying?** Check Yes or No.
18. **18a. Medical history, and 18b, Family medical history.** You must check either Yes or No for each item under this heading. Check Yes for every condition you or an immediate family member has ever had or presently has and describe the condition and approximate date in Item 18c.  
**18c. Explanations.** If information has been reported on a previous application for an airman medical certificate and there has been no change in your condition, you may note "PREVIOUSLY REPORTED, NO CHANGE" in the Explanations block, but you must still check Yes for the condition. Do not report occasional common illnesses such as colds or sore throats. "Substance dependence" is defined by any of the following: Increased tolerance; withdrawal symptoms; impaired control of use; or continued use despite damage to health or impairment of social, personal, or occupational functioning. "Substance abuse" includes the following: Use of an illegal substance, use of a substance or substances in situations in which such use is physically hazardous or misuse of a substance when such misuse has impaired health or social or occupational functioning. "Substances" include alcohol, PCP, marijuana, cocaine, amphetamines, barbiturates, opiates, and other psychoactive chemicals.
19. **Conviction and/or administrative action history.**  
**Item 19a** of this section asks if you have ever been:
  - i. Convicted (which may include paying a fine or forfeiting bond or collateral) of an offense involving driving while intoxicated

- by, while impaired by, or while under the influence of alcohol or a drug; or
- ii. Convicted of or subject to an administrative action for an offense for which your licence was denied, suspended, cancelled, or revoked or which resulted in attendance at an educational or rehabilitation program. You are *not* required to report individual traffic convictions if they *did not* involve alcohol or a drug; suspension, revocation, cancellation, or denial of driving privileges; or attendance at an educational or rehabilitation program.

If you check Yes, you must give a description of the conviction(s) and/or administrative action(s) in **Item 19c, Explanations**. The description must include the:

- i. Alcohol or drug offense for which you were convicted or the type of administrative action involved (e.g., attendance at an alcohol treatment program in lieu of conviction; licence denial, suspension, cancellation, or revocation for refusal to be tested; educational safe driving program for multiple speeding convictions; etc.);
- ii. Name of the State or other jurisdiction involved; and
- iii. Date of the conviction and/or administrative action.

The CAA-B may check State motor vehicle driving licensing records to verify your responses.

**Item 19b** of this section asks if you have ever had any other (non-traffic) convictions (e.g., assault, battery, public intoxication, robbery, etc.). If you check yes, enter the charge for which you were convicted and the date of the conviction in Item 19c.

**19c. Explanations.** If more space is required, use a plain sheet of paper to record the information and then sign and date the paper.

20. **Visit to health professional within the last 3 years?** Check Yes or No. If yes, list all visits in the last 3 years to a physician, physician's assistant, nurse practitioner, psychologist, clinical social worker, or substance abuse specialist for treatment, examination, or medical/mental evaluation. List visits for counselling only if related to a personal substance abuse or psychiatric condition. Give the date, name, address, and type of health professional

consulted and briefly state the reason for consultation. Multiple visits to one health professional for the same condition may be aggregated on one line. Routine dental, eye, and CAA-B periodic medical examinations and consultations with your employer-sponsored Employee Assistance Program (EAP) may be excluded unless the consultations were for your substance abuse or unless they resulted in referral for psychiatric evaluation or treatment. If more space is required, use a plain sheet of paper to record the information and then sign and date the paper.

21. This applicant's declaration certifies the completeness and truthfulness of your responses on the medical application, acknowledging that falsification is punishable by law. You must sign and date the application after you have read the declaration. This applicant declares that you acknowledge that falsification on this form is punishable by law.