MEDICAL CERTIFICATE APPLICATION

INSTRUCTIONS
Kindly type to complete. Please be guided by instructions for completion on page 4.

A. APPLICANT INFORMATION

1. Class of Medical Certificate Applied for: ☐ 1 ☐ 2 ☐ 3 — Clear Form

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. Sex: ☐ Male ☐ Female

10. Types of licences you currently hold:

☐ None	☐ ATC	☐ Flight Instructor	☐ Balloon
☐ Airline Transport	☐ Flight Engineer	☐ Private	☐ Glider
☐ Commercial Pilot	☐ Remote Pilot	☐ Student Pilot Authorisation	☐ Other_____
☐ Multi-crew Pilot	☐ Cabin Crew		

11. Occupation:	12. Employer (Name and Telephone Number):

13. Has your Airman Medical Certificate ever been denied, suspended, or revoked? ☐ Yes ☐ No If yes, provide date

14. Total Pilot Time (Civilian only): To date_____ Past 6 months_____

15. Date of last medical application: ☐ No prior application

16. Do you currently use any medication (prescription or non-prescription)? ☐ Yes ☐ No

If yes, list medication(s) used and indicate whether previously reported.	Previously Reported	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

17. Do you ever use near-vision contact lenses when flying? ☐ Yes ☐ 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 explanation of the condition on a previous application for an Airman Medical Certificate and there has been no change in your condition (see instructions page).

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

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

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

☐	☐	y. Inherited disorders	☐	☐	z. High cholesterol levels
☐	☐	aa. Diabetes	☐	☐	bb. Glaucoma
☐	☐	cc. Epilepsy	☐	☐	dd. Tuberculosis
☐	☐	ee. Mental illness	☐	☐	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	☐	☐	27. Nose	☐	☐
28. Sinuses	☐	☐	29. Mouth and throat	☐	☐
30. Ears, general (internal and external canals, hearing under item 50)	☐	☐	31. Ear drums (perforation)	☐	☐
32. Eyes, general (vision under item 51)	☐	☐	33. Ophthalmoscopic	☐	☐
34. Pupils (equality and reaction)	☐	☐	35. Ocular motility (associated parallel movement, nystagmus)	☐	☐
36. Lungs and chest (not including breast examination)	☐	☐	37. Heart (precordial activity, rhythm, sounds and murmurs)	☐	☐
38. Vascular system (pulse, amplitude and character, arms, legs, others)	☐	☐	39. Abdomen and viscera (including hernia)	☐	☐
40. Anus (not including digital examination)	☐	☐	41. Skin	☐	☐
42. G-U system (not including pelvic examination)	☐	☐	43. Upper and lower extremities (strength and range of motion)	☐	☐
44. Spine, other musculoskeletal	☐	☐	45. Identifying body marks, scars, tattoos (size and location)	☐	☐
46. Lymphatics	☐	☐	47. Neurologic (tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)	☐	☐
48. Psychiatric (appearance, behaviour, mood, communication and memory)	☐	☐	49. General systemic	☐	☐

Note: Describe every abnormally 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 ☐ Pass ☐ Fail					Audiometric speech discrimination score:				
Right Ear (Audiometer threshold in decibels)					**Left Ear (Audiometer threshold in decibels)**				
500	1000	2000	3000	4000	500	1000	2000	3000	4000

51. Vision

Distant vision		**Near vision**	**Intermediate vision**	**Colour perception**
Right 20/ Left 20/ Both 20/	**Near Vision:** Corrected to 20/ Corrected to 20/ Corrected to 20/	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

Field of vision: ☐ Normal ☐ 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) ☐ Normal ☐ Abnormal Test	Albumin	Sugar	55. ECG date

56. Sleep Apnoea:

57. Other tests given:

58. 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

59. 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).

60. Disqualifying defects (list by item number):

61. 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 No.:
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. **Sex.** 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:

- 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.);
- Name of the State or other jurisdiction involved; and
- 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.