APPLICATION FORM FOR AN AVIATION MEDICAL ASSESSMENT

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(TO BE COMEPLETED BY THE APPLICANT) **MEDICAL IN CONFIDENCE**

1.Type of Medical Examination		2.Class of Medical Certificate	

3.Date of Examination:			
4.First Name	5.Middle Name	6.Last Name	7.Gender
8.Date of Birth	9.Age	10.Nationality	11.Place/Country of Birth
12.Passport Issue Date	13.Passport Expiry Date	13. Employer	14.Staff Number
15.License Number	16.Occupation/Rank	17.Aircraft Flown	18.Last Medical Expiry Date
19.Hours flown last 6 months	20.Permanent Address	21.Telephone Number	22.Email

23. Type of License Applying For

24. Foreign license details (if applicable)

Type of License	License number	State of Issue	Class	Any Limitation

25. Statement of Demonstrated Ability (SODA) ◯ Yes ◯ No

Serial Number Date

26. Authorisation for Special Issuance *(Attach letter in E-mail)* ◯ Yes ◯ No

27. Have you ever had an aviation Medical Assessment denied, suspended or revoked by any licensing authority?

☐ Yes ☐ No Date Place

If yes, discuss with Medical Examiner (Details):	

28. Any aircraft accident or reported incident since last medical? ☐ Yes ☐ No

Date Place Details

29.Do you drink Alcoholic beverages? ☐ Yes ☐ No	30. Do you smoke tobacco products? ☐ Yes ☐ No	31. Mention any medication you are currently using, including non-prescribed medications, if any?			
		Name			
If yes, weekly intake in units	Number of cigarettes/days	Dose			
		Purpose			

Remarks for items (1) to (31):

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32. General and medical history: Do you have, or have you ever had, any of the following?

History	Yes	No	History	Yes	No
Eye disorders/eye surgery	☐	☐	Unconsciousness for any reason	☐	☐
Spectacles and/or contact lenses ever worn	☐	☐	Neurological disorders;	☐	☐
Spectacle/contact lens prescriptions/change since last medical exam	☐	☐	Heart or vascular disease	☐	☐
Hay fever, or another allergy	☐	☐	High or low blood pressure	☐	☐
Asthma, lung disease	☐	☐	Kidney stone or blood in urine	☐	☐
Deafness, ear disease	☐	☐	Diabetes, hormone disorder	☐	☐
Nose or throat disease or speech disorder	☐	☐	Stomach, liver or intestinal trouble	☐	☐
Head injury or concussion	☐	☐	Are you pregnant	☐	☐
Family history of Tuberculosis	☐	☐	Sexually transmitted disease	☐	☐
Family history of Epilepsy	☐	☐	Admission to hospital	☐	☐
Family history of allergies/ asthma/ eczema	☐	☐	Visit to medical practitioner since last medical examination	☐	☐
Family history of heart disease/high blood pressure/high lipids	☐	☐	Any other illness or injury	☐	☐
Psychological/ psychiatric trouble of any sort	☐	☐	Dizziness or fainting spells	☐	☐
Alcohol/drug/substance abuse	☐	☐	Frequent or severe headaches	☐	☐
Attempted suicide	☐	☐	A positive HIV test	☐	☐
Motion sickness requiring medication	☐	☐	Frequent or severe headaches	☐	☐
Anaemia/Sickle cell trait/other blood disorders	☐	☐	Family history of: Diabetes	☐	☐
Malaria or other tropical disease	☐	☐	Gynaecological, menstrual problems	☐	☐

Remarks for any significant history:

Applicant Signature *Draw your signature*		Date	

AME E-mail *(Choose your AME)*		*Attach necessary documents In the E-mail (if applicable)*

NOTICE:

Please send this form to the CAA Aeromedical Assessor aeromedical@caa.gov.om and copy your assigned Aeromedical Examiner (Get the Email from the Drop-Down List). Be advised that after sending this form you will not eligible of changing your AME unless prior CAA approval is granted. Finally, Please write your name and your license number in the email,in addition please send white background your recent photo. Please make sure that you fill all the fields appropriately and completely to avoid the rejection of the application (use the submit button).

Submit

Clear