**APPLICATION FOR AEROMEDICAL EXAMINER DESIGNATION**

| **SECTION:** | **PERSONNEL LICENSING AEROMEDICAL FORMS** | | | | | | | logo **PEL 501**  **Rev: 02 - Nov/21** |
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| **TITLE:** | **APPLICATION FOR AEROMEDICAL EXAMINER DESIGNATION** | | | | | | |
| 1. **APPLICATION TYPE** | | | | | | | | |
| □ Initial issue □ Renewal □ Change of facility address | | | | | | | | |
| 1. **FACILITY INFORMATION** | | | | | | | | |
| Name of the Facility: | | | | Trading Name (if applicable): | | | | |
| Facility Address (main location and postal number): | | | | Facility Telephone No.: | | | | |
| 1. **APPLICANT DETAILS** | | | | | | | | |
| First Name: | | | Middle Name: | | | Last Name: | | |
| Gender: | | □ Male □ Female | | | | | | |
| Nationality: | |  | | CAA FILE No (if available): | | |  | |
| Name of Employer: | |  | | CAA Authorization (designation) Number (if applicable) | | |  | |
| Mobile Number: | |  | | OMAN National ID Number (if available) | | |  | |
| Facsimile No.  (if any) | |  | | Tel. No. (Office): | | |  | |
| OMAN Postal Address: | |  | | Email: | | |  | |
| Medical Specialty: | | | | | | | | |
| Number of post graduate years in clinical practice: | | | | | | | | |
| Do you hold qualification in Aerospace/Aviation medicine? □ YES □ NO  Qualification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Do you have military flight surgeon experience?□ YES □ NO  If yes, please state the details. | | | | | | | | |
| Do you have Aviation experience as a pilot?□ YES □ NO  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Do you hold a license to practice medicine in OMAN?   * OMAN Ministry of Health (MOH) □ YES □ NO | | | | | | | | |
| Do you hold a license to practice medicine overseas? □ YES □ NO  If yes, please state the details.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **For Renewal only:**  Number of medical tests conducted:  CLASS I:  CLASS II:  CLASS III:  CLASS Cabin Crew:  Others: | | | | | Number of medical Evaluation boards conducted:  As president:  As member: | | | |

|  |  |  |
| --- | --- | --- |
| 1. **CME RECORDS (APPROVED AEROMEDICAL REFRESHER TRAINING DURING LAST DESIGNATION PERIOD)** | | |
| Date (dd/mm/yyyy) | Activity | CME Hours |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**APPLICANT DECLARATION**

I certify that the information provided hereon and in attachments is correct to the best of my knowledge and belief and if granted I hereby accept the authority, duties, and responsibilities, and shall conduct such activities in compliance with CAR FCL-3, and the directives of the Civil Aviation Authority.

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| **Signature of Applicant:** |

NAME OF APPLICANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note: All fields are mandatory and must be completed in English.***

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| **CAA USE ONLY-APPROVAL** | | |
| □ Recommended for all classes □ Not Recommended  □ Recommended with Restricted class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Aeromedical Inspector Name:  Signature: Date: / / | | |
| Aeromedical Assessor Name:  Signature: Date: / / | | |

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| **CHECKLIST** |
| □ Request Letter from the Examiner |
| □ Passport size photo with white background |
| □ Passport copy with visa page ( if applicable) |
| □ Copy of the Applicant’s qualifications ***(for Initial only)*** |
| □ Copy of the Aviation Medicine Certificate ***(for Initial only)*** |
| □ Copy of the CME records for the past two years ***(for renewal only)*** |
| □ Copy of Oman license |
| □ Copy of the CAA medical facility approval |
| □ Applicant’s Resume stating the applicant’s clinical experience. |
| □ Fees of OMR /……. should be submitted with Initial and/or renewal applications |
| □ Fast Track Application – additional OMR……………. (Within ten working days) |

***Notes: All fields are mandatory and must be completed in English.***