Italian Civil Aviation Authority

ENAC
ENTE NAZIONALE PER L'AVIAZIONE CIVILE
ITALIAN CIVIL AVIATION AUTHORITY

Italy

APPLICATION FORM FOR A MEDICAL CERTIFICATE

COMPLETE THIS PAGE FULLY AND IN BLOCK CAPITALS - REFER TO INSTRUCTIONS PAGES FOR DETAILS

Medical in Confidence

(1) State applied to:

(2) Class of medical certificate applied for: ☐ 1 ☐ 2 ☐ LAPL ☐ 3 ☐ Cabin Crew

(3) Surname:

(4) Previous surname(s):

(5) Forename(s):

(6) Date of birth:

(7) Sex: ☐ Male ☐ Female

(8) Place and country of birth:

(9) Nationality:

(10) Permanent address:

Telephone No.:
Mobile No.:
E-Mail:

(11) Postal address (if different):

Telephone No.:

(12) Application:
☐ Initial
☐ Renewal/Revalidation

(13) Reference number:

Social Security Number

(14) Type of licence applied for:

(15) Occupation (principal):

(16) Employer:

(17) Last medical examination:
Date:
Place:

(18) Licence(s) held (type): Licence number: State of issue:

(19) Any limitations on licence(s)/medical certificate held:
☐ No ☐ Yes
Details:

(20) Have you ever had medical certificate denied, suspended or revoked by any licensing authority?
☐ No ☐ Yes Date: Country:
Details:

(21) Flight time total:

(22) Flight time since last medical:

(23) Aircraft class/type(s) presently flown:

(24) Any aviation accident or reported incident since the last medical examination?
☐ No ☐ Yes Date: Place:
Details:

(25) Type of flying intended:

(26) Current flying activity: ☐ Single pilot ☐ Multi pilot
Current ATCO activity: ☐ ADI ☐ APS ☐ ACS

(27) Do you drink alcohol? ☐ No ☐ Yes, amount

(28) Do you currently use any medication ☐ No ☐ Yes
State medication, dose, date started and why:

(29) Do you smoke tobacco?
☐ No, never ☐ No, date stopped:
☐ Yes, state type and amount:

General and medical history: Do you have, or have you ever had, any of the following? (Please tick). If yes, give details in remarks section (30).

	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) Spectacles/ 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) Sleep disorder/apnoea syndrome	☐	☐	(172) High cholesterol level	☐	☐
(105) Asthma, lung disease	☐	☐	(116) Unconsciousness for any reason	☐	☐	(127) Musculoskeletal illness/impairment	☐	☐	(173) Epilepsy	☐	☐
(106) Heart or vascular trouble	☐	☐	(117) Neurological disorders: stroke, epilepsy, seizure, paralysis etc.	☐	☐	(128) Any other illness or injury	☐	☐	(174) Mental illness or suicide	☐	☐
(107) High or low blood pressure	☐	☐	(118) Psychological/psychiatric trouble of any sort	☐	☐	(129) Admission to hospital	☐	☐	(175) Diabetes	☐	☐
(108) Kidney stone or blood in urine	☐	☐	(119) Alcohol/drug/substance abuse	☐	☐	(130) Visit to medical practitioner since last medical examination	☐	☐	(176) Tuberculosis	☐	☐
(109) Diabetes, hormone disorder	☐	☐	(120) Attempted suicide or self-harm	☐	☐	(131) Refusal of life insurance	☐	☐	(177) Allergy/asthma/eczema	☐	☐
(110) Stomach, liver or intestinal trouble	☐	☐	(121) Motion sickness requiring medication	☐	☐	(132) Refusal of pilot/ATCO licence	☐	☐	(178) Inherited disorders	☐	☐
(111) Deafness, ear disorder	☐	☐	(122) Anaemia / Sickle cell trait/ other blood disorders	☐	☐	(133) Medical rejection from or for military service	☐	☐	(179) Glaucoma	☐	☐
						(134) Award of pension or compensation for injury or illness	☐	☐	**Females only**		
									(150) Gynaecological, menstrual problems	☐	☐
									(151) Are you pregnant?	☐	☐

(30) Remarks: If previously reported and no change since, so state.

(31) Declaration: I hereby declare that I have carefully considered the statements made above and 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 licensing 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.

CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby authorise the release of all information contained in this report and any or all attachments to the AME and where necessary, to the medical assessor of my licensing authority, to the medical assessor of the competent authority of my AME and to relevant medical professionals for the purpose of completion of an aero-medical assessment or a secondary review, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times.

NOTIFICATION OF DISCLOSURE OF PERSONAL DATA: I hereby declare that I have been informed and I understand that the data contained in my medical certificate according to ARA.MED.130 may be electronically stored and made available to my AME in order to provide historical data required in MED.A.035(b)(2)(ii)/(iii) and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of ARA.MED.150(c)(4).

Date	Signature of applicant	Signature of AME / medical assessor	Examiner's Name and Address: