

APPLICATION FORM FOR A MEDICAL CERTIFICATE - Class 1, 2, 3 & LAPL



Civil Aviation Directorate

Transport Malta – Civil Aviation Directorate Pantar Road, Lija, LJA 2021, Malta. Tel: +356 2555 5000 ams.tm@transport.gov.mt www.transport.gov.mt

Complete this page fully and in **BLOCK CAPITALS** – Refer to instructions for completion.

MEDICAL IN CONFIDENCE

(1) State of licence issue:		(2) Medical certificate applied for: Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> LAPL <input type="checkbox"/> Class 3 <input type="checkbox"/>	
(3) Surname:		(4) Previous surname(s):	
(5) Forename(s):		(6) Date of birth (dd/mm/yyyy):	(7) Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
(8) Place and country of birth:		(9) Nationality:	
(10) Permanent address: Country: Telephone No.: Mobile No.: e-mail:		(11) Postal address (if different): Country: Telephone No.:	
(18) Licence(s) held (type): Licence number: State of issue:		(19) Any limitations on licence(s)/medical certificate held: No <input type="checkbox"/> Yes <input type="checkbox"/> Details:	
(20) Have you ever had a medical certificate denied, suspended, revoked by any licensing authority? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ Country: _____ Details:		(21) Flight time total:	(22) Flight time since last medical:
(24) Any aviation accident or medical event whilst exercising the privileges of the licence since the last medical examination? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ Place: _____ Details:		23) Aircraft class/type(s) presently flown:	
(27) Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, state average weekly amount: Do you use drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, state the type:		(25) Current/intended pilot activity: Commercial <input type="checkbox"/> Non-commercial <input type="checkbox"/> Other Single-pilot <input type="checkbox"/> Multi-pilot <input type="checkbox"/>	
(29) Do you smoke tobacco? <input type="checkbox"/> No, never <input type="checkbox"/> No, date stopped: _____ <input type="checkbox"/> Yes, state type and amount:		(26) Current/intended ATC activity: ADC <input type="checkbox"/> APS <input type="checkbox"/> ACS <input type="checkbox"/> ADV <input type="checkbox"/> APP <input type="checkbox"/> ACP <input type="checkbox"/>	
		(28) Do you currently use any medication? No <input type="checkbox"/> Yes <input type="checkbox"/> State medication, dose, date started and why:	

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

Yes No		Yes No		Yes No		Family history of:		Yes No	
101 Eye trouble/eye operation		112 Nose, throat or speech disorder		123 Malaria or other tropical disease		170 Heart or vascular disease			
102 Spectacles and/or contact lenses ever worn		113 Head injury or concussion		124 A positive HIV test		171 High blood pressure			
103 Spectacle/contact lens prescriptions change since last medical exam.		114 Frequent or severe headaches		125 Sexually transmitted disease		172 High cholesterol level			
		115 Dizziness or fainting spells		126 Sleep disorder/apnoea syndrome		173 Epilepsy			
104 Hay fever, other allergy		116 Unconsciousness for any reason		127 Musculoskeletal illness/impairment		174 Mental illness or suicide			
105 Asthma, lung disease				117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.		128 Any other illness or injury		175 Diabetes	
106 Heart or vascular trouble		118 Psychological/psychiatric trouble of any sort		129 Admission to hospital		176 Tuberculosis			
107 High or low blood pressure				119 Misuse of psychoactive substance		130 Visit to medical practitioner or mental health specialist since last medical examination		177 Allergy/asthma/eczema	
108 Kidney stone or blood in urine		120 Attempted suicide, or self-harm		131 Refusal of life insurance		178 Inherited disorders			
109 Diabetes, hormone disorder				121 Motion sickness requiring medication		132 Refusal of aviation licence		179 Glaucoma	
110 Stomach, liver or intestinal trouble		122 Anaemia/sickle cell trait/other blood disorders		133 Medical rejection from or for military service		Females only:			
111 Deafness, ear disorder				134 Award of pension or compensation for injury or illness		150 Gynaecological, menstrual problems			
						151 Are you pregnant?			

(30) Remarks:

(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 statements. I understand that, if I have made any false or misleading statements 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.

I hereby declare that I have been informed and I understand all information provided to my AME contained in this report and its attachments and all information which is provided to my licensing authority and that related to me, may be released, to the medical assessor of my licensing authority, other health professionals and medical administrative staff as part of the aero-medical assessment process and to the medical assessor of the competent authority of my AME, recognising that these documents or electronically stored data are to be used for the completion of an aero-medical assessment and for oversight purposes, providing that I or my physician may have access to them in accordance with 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 in accordance with point ARA.MED.130 or, point ATCO.AR.F.005 of Regulation (EU) 2015/340 if applicable may be electronically sorted and made available to my AME in order to provide historical data required in point MED.A.035(b)(2)(ii)/(iii) or, if applicable points ATCO.MED.A.035(b)(2)(ii) or ATCO.MED.035(b)(2)(iii), and to the medical assessors of the competent authorities of the Member States in order /to facilitate the enforcement of point ARA.MED.150(c)(4).

Date Signature of applicant Signature of AME/(medical assessor)

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INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FORM FOR A MEDICAL CERTIFICATE

This application form and all attached report forms will be transmitted to the licensing authority. Medical confidentiality shall be respected at all times.

The applicant should personally complete, in full, all questions (sections) on the application form. Writing should be legible and in block capitals, using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any questions, a plain sheet of paper should be used, bearing the applicant's name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the application form for a medical certificate.

Failure to complete the application form in full, or to write legibly, may result in non-acceptance of the application form. The making of false or misleading statements or the withholding of relevant information in respect of this application may result in criminal prosecution, denial of this application and/or withdrawal of any medical certificate(s) granted.

<p>1. LICENSING AUTHORITY: State name of country that has issued the pilot or ATCO licence or where a licence has not been issued, the country where the applicant intends to apply for a licence.</p>	<p>17. LAST APPLICATION FOR A MEDICAL CERTIFICATE: State date (day, month, year) and place (town, country). Initial applicants state 'NONE'.</p>
<p>2. MEDICAL CERTIFICATE APPLIED FOR: Tick appropriate box representing the type of medical certificate applied for, e.g. class 1, class 2, class 3 or LAPL.</p>	<p>18. LICENCE(S) HELD (TYPE): State type of licence(s) held. Enter licence number and State of issue. If no licences are held, state 'NONE'.</p>
<p>3. SURNAME: State surname/family name</p>	<p>19. ANY LIMITATIONS ON THE LICENCE(S)/MEDICAL CERTIFICATE: Tick appropriate box and give details of any limitations on your licence(s)/medical certificate, e.g. vision, colour vision, safety pilot, etc</p>
<p>4. PREVIOUS SURNAME(S): If your surname or family name has changed for any reason, state previous name(s).</p>	<p>20. MEDICAL CERTIFICATE DENIAL, SUSPENSION OR REVOCATION: Tick 'YES' box if you have ever had a medical certificate denied, suspended or revoked. If 'YES', state date (dd/mm/yyyy) and country where it occurred.</p>
<p>5. FORENAME(S): State first and middle names (maximum three).</p>	<p>21. FLIGHT TIME TOTAL: State total number of hours flown</p>
<p>6. DATE OF BIRTH: Specify in order dd/mm/yyyy.</p>	<p>22. FLIGHT TIME SINCE LAST MEDICAL: State number of hours flown since your last medical examination.</p>
<p>7. SEX: Tick appropriate box.</p>	<p>23. AIRCRAFT CLASS/TYPE(S) PRESENTLY FLOWN: State name of principal aircraft flown, e.g. Boeing 737, Cessna 150, etc</p>
<p>8. PLACE AND COUNTRY OF BIRTH: State town and country of birth.</p>	<p>24. ANY AVIATION ACCIDENT OR MEDICAL EVENT WHILST EXERCISING THE PRIVILEGES OF THE LICENCE SINCE THE LAST MEDICAL EXAMINATION: If 'YES' box ticked, state date (dd/mm/yyyy) and country of occurrence and provide details.</p>
<p>9. NATIONALITY: State name of country of citizenship.</p>	<p>25. CURRENT/INTENDED PILOT ACTIVITY: Please tick the appropriate box regarding the current/intended activity during the following certification period:</p> <ul style="list-style-type: none"> Commercial, non-commercial or other (for other, please specify the type of operation) Single-pilot or multi-pilot
<p>10. PERMANENT ADDRESS: State permanent postal address and country. Enter telephone area code as well as telephone number.</p>	<p>26. CURRENT/INTENDED ATC ACTIVITY: Please tick the appropriate box regarding the current/intended activity during the following certification period e.g. ADC, APS, ACS</p>
<p>11. POSTAL ADDRESS (IF DIFFERENT): If different from permanent address, state full current postal address including telephone number and area code. If the same, enter 'SAME'.</p>	<p>27. DO YOU DRINK ALCOHOL OR USE DRUGS? Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 litres of beer.</p>
<p>12. APPLICATION: Tick appropriate box</p>	<p>28. DO YOU CURRENTLY USE ANY MEDICATION?: If 'YES', give full details - name, how much you take and when, etc. Include any non-prescription medication.</p>
<p>13. MEDICAL CERTIFICATE/EAMR ID NUMBER: State medical certificate number allocated to you by the licensing authority/EAMR ID unique number Initial applicants enter 'NONE'.</p>	<p>29. DO YOU SMOKE TOBACCO? Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (e.g. 2 cigars daily; pipe – 1 oz. weekly)</p>
<p>14. TYPE OF LICENCE APPLIED FOR: State type of licence applied for from the following list: Airline Transport Pilot Licence* Multi-Pilot Licence* Commercial Pilot Licence/Instrument Rating* Commercial Pilot Licence* Private Pilot Licence/Instrument Rating* Private Pilot Licence* Sailplane Pilot Licence Balloon Pilot Licence Light Aircraft Pilot Licence* Air Traffic Controller Licence Other – Please specify *Please specify whether Fixed Wing / Rotary Wing / Both</p>	<p>30. GENERAL AND MEDICAL HISTORY All items under this heading, from number 101 to 179 inclusive, should have the answer 'YES' or 'NO' ticked. You should tick 'YES' if you have ever had the condition in your life and describe the condition and approximate date in the remarks section (30). All questions asked are medically important even though this may not be readily apparent. Items numbered 170 to 179 relate to immediate family history, whereas items numbered 150 to 151 should be answered by female applicants only. Do not report occasional common illnesses such as colds.</p>
<p>15. OCCUPATION (PRINCIPAL): Indicate your principal employment.</p>	<p>31. DECLARATION AND NOTIFICATION OF DISCLOSURE OF PERSONAL DATA: Do not sign or date these declarations until indicated to do so by the AME/GMP who will act as witness and sign accordingly.</p>
<p>16. EMPLOYER: If principal occupation is pilot, then state employer's name or if self employed, state 'self'.</p>	

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Data Protection Notice

All data collected in this form is processed in accordance with the Privacy Laws that include General Data Protection Regulation (EU) 2016/679 and Chapter 586 of the Laws of Malta (Data Protection Act). The data provided may be exchanged with other Public Authorities and/or Government Departments as required and permitted by Maltese Law. Transport Malta of Triq Pantar, Lija, Malta LJA2021 is the data controller for the purpose of the privacy laws. The Privacy Notice attached with this application sets out the way in which personal information/data is collected and processed by Transport Malta, as well as the steps that are taken to protect such information.

Data Protection Privacy Notice

Transport Malta of Triq Pantar, Lija, Malta LJA2021 is the Data Controller for the purpose of the Data Protection Act CAP. 586 and General Data Protection Regulation (EU) 2016/679 (GDPR). This Privacy Notice sets out the way in which we collect and process your Personal Information, as well as the steps we take to protect such information.

1. The information we collect and how we use it

- 1.1. From this application form Transport Malta collects different types of information which information is that required by Law and is used explicitly for your particular application. It is to be noted that if the required information is not provided the said application cannot be processed.
- 1.2. The primary purpose for collecting information is mainly to process the application for the service being applied for, however, your personal information may also be used for related purposes that amongst other include: sending notifications, renewal of licence/certificate after expiry period, and for the provision of information with regards to any legislative amendments which may affect the services offered to you.

2. To whom we disclose information

- 2.1. This information will be solely used for the reasons detailed above. However there may be cases where personal information is shared with the following third parties for reasons listed below:
 - Any third party offering assistance in providing the required service;
 - Any law enforcement body who may have any reasonable requirement to access your personal information;
 - Third party entities responsible for the data processing contracted by Transport Malta.

3. Data Subject Rights

- 3.1. With respect to your privacy rights, Transport Malta is obliged to provide you with reasonable access to the Personal Data that you have provided to us. Your other principal rights under data protection law are:
 - a. the right for information;
 - b. the right to access;
 - c. the right to rectification;
 - d. the right to erasure;
 - e. the right to restrict processing;
 - f. the right to object to processing;
 - g. the right to data portability;
 - h. the right to complain to a supervisory authority; and
 - i. the right to withdraw consent.
- 3.2. If you wish to access or amend any Personal Data we hold about you, or to request that we delete any information about you, you may contact us by sending a request to dataprotection.tm@transport.gov.mt. We will acknowledge your request within seventy-two (72) hours and will do our utmost to handle it promptly. We will respond to these requests within a month, with a possibility to extend this period for particularly complex requests in accordance with Applicable Law.
- 3.3. At any time, you may object to the processing of your Personal Data, on legitimate grounds, except if otherwise permitted by applicable law.
- 3.4. In accordance with Applicable Law, we reserve the right to withhold personal data if disclosing it would adversely affect the rights and freedoms of others. Moreover, we reserve the right to charge a fee for complying with such requests if they are deemed manifestly unfounded or excessive.

4. Retention period

- 4.1. Personal data will be retained for not more than 3 months from date of application should the application not be submitted complete or is rejected.
- 4.2. Once the service related to your application is provided, we will retain your information for as long as needed to provide you with our service, or to comply with our legal obligations, resolve disputes and enforce our agreements.

5. Security

- 5.1. We take appropriate security measures to protect against loss, misuse and unauthorized access, alteration, disclosure, or destruction of your information. Additionally, steps will also be taken to ensure the ongoing confidentiality, integrity, availability, and resilience of systems and services processing personal information, and will restore the availability and access to information in a timely manner in the event of a physical or technical incident. All information gathered is kept confidential and is used solely for the purpose indicated herein.
- 5.2. If we learn of a security systems breach, we will inform you of the occurrence of the breach in accordance with applicable law.

6. Governing Law

All data collected in this form is processed in accordance with the Privacy Laws that include General Data Protection Regulation (EU) 2016/679 and Chapter 586 of the Laws of Malta (Data Protection Act).

7. Data Protection Officer

- 7.1. Transport Malta has a Data Protection Officer ("DPO") who is responsible for matters relating to privacy and data protection. The DPO can be reached at the above address or by email: dataprotection.tm@transport.gov.mt

8. Contacting us

- 8.1. Please address any questions, comments and requests regarding the application process to civil.aviation@transport.gov.mt

APPLICATION FORM FOR A MEDICAL CERTIFICATE - Class 1, 2, 3



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MEDICAL EXAMINATION REPORT FORM FOR CLASS 1, 2 & 3 APPLICANTS

MEDICAL IN CONFIDENCE

(201) Examination category Initial <input type="checkbox"/> Revalidation <input type="checkbox"/> Renewal <input type="checkbox"/> Referral <input type="checkbox"/>	(202) Height (cm)	(203) Weight (kg)	(204) Colour eye	(205) Colour hair	(206) Blood pressure-seated (mmHg)		(207) Pulse - resting	
					Systolic	Diastolic	Rate (bpm)	Rhythm: regular <input type="checkbox"/> irregular <input type="checkbox"/>
Clinical exam: Check each item			Normal	Abnormal			Normal	Abnormal
(208) Head, face, neck, scalp					(218) Abdomen, hernia, liver, spleen			
(209) Mouth, throat, teeth					(219) Anus, rectum			
(210) Nose, sinuses					(220) Genito-urinary system			
(211) Ears, drums, eardrum motility					(221) Endocrine system			
(212) Eyes - orbit & adnexa; visual fields					(222) Upper & lower limbs, joints			
(213) Eyes - pupils and optic fundi					(223) Spine, other musculoskeletal			
(214) Eyes - ocular motility; nystagmus					(224) Neurologic - reflexes, etc.			
(215) Lungs, chest, breasts					(225) Mental Health			
(216) Heart					(226) Skin, identifying marks and lymphatics			
(217) Vascular system					(227) General systemic			
(228) Notes: Describe every abnormal finding. Enter applicable item number before each comment.								

Visual acuity

(229) Distant vision at 5m/6m

	Uncorrected		Spectacles	Contact lenses
		Corr. to		
Right eye				
Left eye				
Both eyes				

(230) Intermediate vision

	Uncorrected		Corrected	
	Yes	No	Yes	No
N14 at 100cm				
Right eye				
Left eye				
Both eyes				

(231) Near vision

	Uncorrected		Corrected	
	Yes	No	Yes	No
N5 at 30-50cm				
Right eye				
Left eye				
Both eyes				

(232) Spectacles

Yes No Type: _____

(233) Contact lenses

Yes No Type: _____

Refraction	Sph	Cyl	Axis	Add
	Right eye			
Left eye				

(231) Colour Perception

Normal Abnormal

Pseudo-isochromatic plates Type: Ishihara (24 plates)
No of plates: _____ No of errors: _____

(234) Hearing

(when 239/241 not performed)		Right ear	Left ear
Conversational voice test (2m) with back turned to examiner		Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
		No <input type="checkbox"/>	No <input type="checkbox"/>
Audiometry			
Hz	500	1000	2000
Right			
Left			

(249) AME declaration:

I hereby certify that I/my AME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

(250) Place and date:	AME name and address:	AME certificate No.:
	E-mail:	
	Telephone No.:	
AME signature:		

(236) Pulmonary function

(237) Haemoglobin

FEV ₁ /FVC _____%	_____ (unit)
Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

(236a) OSA screening

Applicant at risk of OSA: Yes No

Specify if applicant undergoes treatment for OSA:

(235) Urinalysis Normal Abnormal

Glucose	Protein	Blood	Other
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Accompanying reports

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) AME recommendation:

Name of applicant _____ Date of birth: _____ Reference number: _____

Fit for class: _____

Medical certificate issued by undersigned (copy attached) for class: _____

Unfit for class: _____

Deferred for further evaluation. If yes, why and to whom?

(248) Comments, limitations

APPLICATION FORM FOR A MEDICAL CERTIFICATE - Class 1, 2, 3



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MEDICAL EXAMINATION REPORT FORM FOR LAPL APPLICANTS

MEDICAL IN CONFIDENCE

Shaded areas do not require completion

(201) Examination category Initial <input type="checkbox"/> Revalidation <input type="checkbox"/> Renewal <input type="checkbox"/> Special Referral <input type="checkbox"/>	(202) Height (cm)	(203) Weight (kg)	(204) Colour eye	(205) Colour hair	(206) Blood pressure-seated (mmHg)		(207) Pulse - resting	
					Systolic	Diastolic	Rate (bpm)	Rhythm: regular <input type="checkbox"/> irregular <input type="checkbox"/>
Clinical exam: Check each item				Normal	Abnormal	Normal	Abnormal	
(208) Head, face, neck, scalp						(218) Abdomen, hernia, liver, spleen		
(209) Mouth, throat, teeth						(219) Anus, rectum		
(210) Nose, sinuses						(220) Genito-urinary system		
(211) Ears, drums, eardrum motility						(221) Endocrine system		
(212) Eyes - orbit & adnexa; visual fields						(222) Upper & lower limbs, joints		
(213) Eyes - pupils and optic fundi						(223) Spine, other musculoskeletal		
(214) Eyes - ocular motility; nystagmus						(224) Neurologic - reflexes, etc.		
(215) Lungs, chest, breasts						(225) Mental Health		
(216) Heart						(226) Skin, identifying marks and lymphatics		
(217) Vascular system						(227) General systemic		
(228) Notes: Describe every abnormal finding. Enter applicable item number before each comment.								

Visual acuity

(229) Distant vision at 5m/6m

	Uncorrected		Spectacles	Contact lenses
		Corr. to		
Right eye				
Left eye				
Both eyes				

(230) Intermediate vision

N14 at 100cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(231) Near vision

N5 at 30-50cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(232) Spectacles

Yes No

Type:

(233) Contact lenses

Yes No

Type:

Refraction	Sph	Cyl	Axis	Add
Right eye				
Left eye				

(313) Colour perception

Normal Abnormal

Pseudo-isochromatic plates

Type: Ishihara (24 plates)

No of plates:

No of errors:

(234) Hearing

(when 239/241 not performed)

Right ear Left ear

Conversational voice test (2m) with back turned to examiner	Yes	No	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Audiometry

Hz	500	1000	2000	3000
Right				
Left				

(249) AME declaration:

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

(250) Place and date:	AME name and address:	AME certificate No.:
	E-mail:	
	Telephone No.:	
AME signature:		

(236) Pulmonary function

FEV ₁ /FVC _____%	(237) Haemoglobin _____ (unit)
Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

(235) Urinalysis

Normal

Abnormal

Glucose	Protein	Blood	Other

Accompanying reports

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) AME recommendation:

Name of applicant Date of birth: Reference number:

Fit for medical certificate for LAPL

Medical certificate issued by undersigned (copy attached) for LAPL

Unfit for class: -----

Deferred for further evaluation. If yes, why and to whom?

(248) Comments, limitations

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INSTRUCTIONS FOR COMPLETION OF THE MEDICAL EXAMINATION REPORT FORMS

The AME performing the examination should verify the identity of the applicant.

All questions (sections) on the medical examination report form should be completed in full. If an otorhinolaryngology examination report form is attached, then questions 209, 210, 211, and 234 may be omitted. If an ophthalmology examination report form is attached, then questions 212, 213, 214, 229, 230, 231, 232, and 233 may be omitted.

Writing should be legible and in block capitals using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any question, a plain sheet of paper should be used, bearing the applicant's name, the AME's name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the medical examination report form.

Failure to complete the medical examination report form in full, as required, or to write legibly, may result in non-acceptance of the application in total and may lead to withdrawal of any medical certificate issued. The making of false or misleading statements or the withholding of relevant information by an AME may result in criminal prosecution, denial of an application or withdrawal of any medical certificate(s) granted.

Shaded areas do not require completion for the medical examination report form for the LAPL.

- 201 EXAMINATION CATEGORY – Tick appropriate box. Initial – Initial examination for either LAPL, class 1, 2 or 3; also initial examination for upgrading from LAPL to class 2, or from class 2 to 1 (insert 'upgrading' in box 248). Renewal/Revalidation – Subsequent ROUTINE examinations. Extended Renewal/Revalidation – Subsequent ROUTINE examinations, which include comprehensive ophthalmological and otorhinolaryngology examinations.
- 202 HEIGHT – Measure height, without shoes, in centimetres to nearest cm.
- 203 WEIGHT – Measure weight, in indoor clothes, in kilograms to nearest kg.
- 204 COLOUR EYE – State colour of applicant's eyes from the following list: brown, blue, green, hazel, grey, multi.
- 205 COLOUR HAIR – State colour of applicant's hair from the following list: brown, black, red, fair, bald.
- 206 BLOOD PRESSURE – Blood pressure readings should be recorded as Phase 1 for Systolic pressure and Phase 5 for Diastolic pressure. The applicant should be seated and rested. Recordings in mm Hg.
- 207 PULSE (RESTING) – The pulse rate should be recorded in beats per minute and the rhythm should be recorded as regular or irregular. Further comments if necessary may be written in section 228, 248 or separately.
- 208 to 227 inclusive constitute the general clinical examination, and each of the boxes should be marked (with a tick) as normal or abnormal.
- 208 HEAD, FACE, NECK, SCALP – To include appearance, range of neck and facial movements, symmetry, etc.
- 209 MOUTH, THROAT, TEETH – To include appearance of buccal cavity, palate motility, tonsillar area, pharynx and also gums, teeth and tongue.
- 210 NOSE, SINUSES – To include appearance and any evidence of nasal obstruction or sinus tenderness on palpation.
- 211 EARS, DRUMS, EARDRUM MOTILITY – To include otoscopy of external ear, canal, tympanic membrane. Eardrum motility by Valsalva manoeuvre or by pneumatic otoscopy.
- 212 EYES – ORBIT AND ADNEXA; VISUAL FIELDS – To include appearance, position and movement of eyes and their surrounding structures in general, including eyelids and conjunctiva. Visual fields check by campimetry, perimetry or confrontation.
- 213 EYES – PUPILS AND OPTIC FUNDI – To include appearance, size, reflexes, red reflex and fundoscopy. Special note of corneal scars.
- 214 EYES – OCULAR MOTILITY, NYSTAGMUS – To include range of movement of eyes in all directions; symmetry of movement of both eyes; ocular muscle balance; convergence; accommodation; signs of nystagmus.
- 215 LUNGS, CHEST, BREASTS – To include inspection of chest for deformities, operation scars, abnormality of respiratory movement, auscultation of breath sounds. Physical examination of female applicant's breasts should only be performed with informed consent.
- 216 HEART – To include apical heartbeat, position, auscultation for murmurs, carotid bruits, palpation for trills.
- 217 VASCULAR SYSTEM – To include examination for varicose veins, character and feel of pulse, peripheral pulses, evidence of peripheral circulatory disease.
- 218 ABDOMEN, HERNIA, LIVER, SPLEEN – To include inspection of abdomen; palpation of internal organs; check for inguinal hernias in particular.
- 219 ANUS, RECTUM – Examination only on clinical indication following an informed consent.
- 220 GENITO-URINARY SYSTEM – To include renal palpation; inspection palpation male/female reproductive organs only on clinical indication following an informed consent.
- 221 ENDOCRINE SYSTEM – To include inspection, palpation for evidence of hormonal abnormalities/imbalance; thyroid gland.
- 222 UPPER AND LOWER LIMBS, JOINTS – To include full range of movements of joints and limbs, any deformities, weakness or loss. Evidence of arthritis.
- 223 SPINE, OTHER MUSCULOSKELETAL – To include range of movements, abnormalities of joints.
- 224 NEUROLOGIC – REFLEXES ETC. To include reflexes, sensation, power, vestibular system – balance, Romberg test, etc.
- 225 MENTAL HEALTH – To include appearance, appropriate mood/thought, unusual behaviour.
- 226 SKIN, IDENTIFYING MARKS AND LYMPHATICS – To include inspection of skin; inspection, palpation for lymphadenopathy, etc. Briefly describe scars, tattoos, birthmarks, etc. which could be used for identification purposes.
- 227 GENERAL SYSTEMIC – All other areas, systems and nutritional status.
- 228 NOTES – Any notes, comments or abnormalities to be described – extra notes if required on separate sheet of paper, signed and dated.

Civil Aviation Directorate

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- 229 DISTANT VISION AT 5/6 METRES – Each eye to be examined separately and then both together. First without correction, then with spectacles (if used) and lastly with contact lenses, if used. Record visual acuity in appropriate boxes. Visual acuity to be tested at either 5 or 6 metres with the appropriate chart for the distance.
- 230 INTERMEDIATE VISION AT 100 CM – Each eye to be examined separately and then both together. First without correction, then with spectacles if used and lastly with contact lenses if used. Record visual acuity in appropriate boxes as ability to read N14 at 100 cm (Yes/No).
- 231 NEAR VISION AT 30-50 CM. – Each eye to be examined separately and then both together. First without correction, then with spectacles if used and lastly with contact lenses, if used. Record visual acuity in appropriate boxes as ability to read N5 at 30-50 cm (Yes/No).
- Note: Bifocal contact lenses and contact lenses correcting for near vision only are not acceptable.
- 232 SPECTACLES – Tick appropriate box signifying whether spectacles are or are not worn by applicant. If used, state whether unifocal, bifocal, varifocal or look-over.
- 233 CONTACT LENSES – Tick appropriate box signifying if contact lenses are or are not worn. If worn, state type from the following list; hard, soft, gas-permeable or disposable.
- 313 COLOUR PERCEPTION – Tick appropriate box signifying if colour perception is normal or not. If abnormal; state number of plates of the first 15 of the pseudo-isochromatic plates (Ishihara 24 plates) have not been read correctly.
- 234 HEARING – Tick appropriate box to indicate hearing level ability as tested separately in each ear at 2 m.
- 235 URINALYSIS – State whether result of urinalysis is normal or not by ticking appropriate box. If no abnormal constituents, state NIL in each appropriate box.
- 236 PULMONARY FUNCTION – When required or on indication, state actual FEV1/FVC value obtained in % and state whether normal or not with reference to height, age, sex and race.
- 236(a) OSA screening: Determine the risk of OSA using appropriate diagnostic tool.
- 237 HAEMOGLOBIN – Enter actual haemoglobin test result and state units used. Then state whether normal value or not, by ticking appropriate box.
- 238 to 244 inclusive: ACCOMPANYING REPORTS – One box opposite each of these sections must be ticked. If the test is not required and has not been performed, then tick the NOT PERFORMED box. If the test has been performed (whether required or on indication) complete the normal or abnormal box as appropriate. In the case of question 244, the number of other accompanying reports must be stated.
- 247 AME RECOMMENDATION – The applicant's name, date of birth and reference number, should be entered here in block capitals. The applicable class of medical certificate should be indicated by a tick in the appropriate box. If a fit assessment is recommended and a medical certificate has been issued, this should be indicated in the appropriate box. An applicant may be recommended as fit for a lower class of medical certificate (e.g. class 2), but also be deferred or recommended as unfit for a higher class of medical certificate (e.g. class 1). If an unfit recommendation is made, applicable Part-MED point references should be entered. If an applicant is deferred for further evaluation, the reason and the doctor or licensing authority to whom the applicant is referred should be indicated.
- 248 COMMENTS, LIMITATIONS, ETC. – The AME's findings and assessment of any abnormality in the history or examination, should be entered here. The AME should also state any limitation required.
- 249 AME DETAILS – The AME should sign the declaration, complete his or her name and address in block capitals, contact details and lastly stamp the relevant section with his or her designated AME stamp incorporating his or her AME number. The GMP identification no. is the number provided by the national medical system.
- 250 PLACE AND DATE – The place (town or city) and the date of examination should be entered here. The date of examination is the date of the general examination and not the date of finalisation of the form. If the medical examination report is finalised on a different date, the date of finalisation should be entered in section 248 as 'Report finalised on