Application for Medical Certificate

False Statement

The making of false statement for the purpose of procuring the grant, issue, revalidation, renewal or variation of any certificate, licence, approval, permission or other document is an offence under the Act 60 of 1960. The Directorate General of Civil Aviation may, in any case in which they think it is desirable, require the applicant to furnish such evidence as they may desire and to make and subscribe a statutory declaration as to the truth of the facts set out in the application.

1. Personal Particulars of Applicant (In BLOCK CAPITALS) **(To be completed by the Applicant)**

(13) DGCA reference number (if known): …… (1) State of licence or Reports issue:

(18) Licence or Reports type held: …… Licence or Reports number: ……

Title: …… (5) Forename: …… (3) Surname: ……

(7) Sex: …… (6) Date of birth: …… (4) Previous surname(s): ……

(8) Place and country of Birth: …… (9) Nationality: ……

(15) Occupation: …… (16) Employer: ……

(10) Applicant Permanent Address: ……

(11) Postal Address (if different): ……

Telephone no: …… Mobile no: ……

Email: …… Languages Spoken: ……

2. Details of Doctor **(To be completed by the Applicant)**

Name: …… Telephone no: ……

Postal Address: …… Post Code: ……

3. Application **(To be completed by the Applicant)**

(12) Initial: ☐ Revalidation: ☐ Renewal: ☐ (14)Type of Licence or Reports Applied for: ……

(17) Last medical examination Date: …… Place: ……

(19) Any limitations on medical certificate: Yes: ☐ No: ☐ Details: ……

(2) Medical Certificate Applied for: Class 1 ☐ Class 2 ☐ Class 3 ☐ LAPL ☐ Cabin Crew Reports ☐

(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority?

Yes: ☐ No: ☐ If yes, discuss with AME. Date: …… Place: ……

Details: ……

(21) Total flight time: …… (22) Flight time since last medical: ……

(23) Aircraft Class/Types presently flown: …… (25) Type of flying intended: ……

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

Date: …… Place: …… Details: ……

(26) Present flying activity Single pilot: ☐ Multi pilot: ☐

(27) Do you drink alcohol – state average weekly intake in units: ……

(29) Do you smoke tobacco? Yes ☐ No ☐ Never: ☐ Date stopped: ……

If yes, State type, amount and no of years: ……

(28) Do you currently use any medication? Yes: ☐ No: ☐

If yes, state medication, dose, date started and why: ……

(3) Surname: ……	(4) Previous surname(s): ……	Title: ……	DGCA Ref no: ……..

General medical history: Do you have, or have you ever had, any of the following? Yes or No (or as indicated) must be ticked after each question. Elaborate Yes answers in the remarks section.

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

(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 that 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: Please read the statement below in relation to disclosure of information. The DGCA takes the security of your personal information very seriously. Information is only disclosed to persons who are subject to a duty of confidentiality and where there are sufficient security measures in place to protect personal data. If you do not consent to the disclosure of information as described below, you may make representations to Kuwait DGCA.

In submitting this application, I am consenting to the disclosure to third parties of all information which I have provided to the DGCA and that relates to me. I understand that information would only be disclosed to third parties by the DGCA for regulatory purposes. This may include providing information to other medical professionals. Administrative workers and/or IT workers who are assisting the DGCA with its regulatory functions may also be given access to personal information in the course of their professional duties.

Date: …….. Signature of applicant: …… Signature of AME (Witness): ……

INSTRUCTION PAGE 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 write legibly, may result in non-acceptance of the application form. The making of false or misleading statements or 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.

1. LICENSING AUTHORITY: State name of country this application is to be forwarded to.	**17. LAST APPLICATION FOR A MEDICAL CERTIFICATE**: State date (day, month, year) and place (town, country). Initial applicants state 'NONE'.
2. MEDICAL CERTIFICATE APPLIED FOR: Tick appropriate box. Class 1: Professional Pilot Class 2: Private Pilot Class 3: ATCO LAPL	**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'.
	500. GP NAME: Completion of this area is optional
3. SURNAME: State Surname/Family name.	**19. ANY LIMITATIONS ON THE LICENCE(S)/MEDICAL CERTIFICATE:** Tick appropriate box and give details of any limitations on your licence(s)/medical certificate eg, vision, colour vision, safety pilot, etc.
4. PREVIOUS SURNAME(S): If your surname or family name has changed for any reason, state previous name(s).	**20. MEDICAL CERTIFICATE DENIAL, SUSPENSION OR REVOCATION:** Tick 'YES' box if you have ever had a medical certificate denied, suspended or revoked, even if only temporary If 'YES', state date (dd/mm/yyyy) and country where occurred.
5. FORENAME(S): State first and middle names (maximum three).	**21. FLIGHT TIME TOTAL:** State total number of hours flown
6. DATE OF BIRTH: Specify in order dd/mm/yyyy	**22. FLIGHT TIME SINCE LAST MEDICAL:** State number of hours flown since your last medical examination.

7. SEX: Tick as appropriate.	**23. AIRCRAFT CLASS/TYPE (S) PRESENTLY FLOWN:** State name of principal aircraft flown, eg Boeing 737, Cessna 150, etc.
8. PLACE AND COUNTRY OF BIRTH: State town and country of birth.	**24. ANY AIRCRAFT ACCIDENT OR REPORTED INCIDENT SINCE LAST MEDICAL EXAMINATION:** If 'YES' box ticked, state Date (dd/mm/yyyy) and Country of accident/Incident.
9. NATIONALITY: State name of country of citizenship.	**25. TYPE OF FLYING INTENDED:** State whether airline, charter, single-pilot, commercial air transport, carrying passengers, agriculture, pleasure, etc.
10. PERMANENT ADDRESS: State permanent postal address and country. Enter telephone area	**26. PRESENT FLYING ACTIVITY:** Tick appropriate box to indicate whether you fly as the SOLE pilot or not.
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'.	**27. DO YOU DRINK ALCOHOL?** Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 litres of beer.
12. APPLICATION: Tick appropriate box.	**28. DO YOU CURRENTLY USE ANY MEDICATION?:** If 'YES', give full details - name, how much do you take and when, etc. Include any non-prescription medication.
13. REFERENCE NUMBER: State Reference Number allocated to you by the licensing authority. Initial applicants enter 'NONE'.	**29. DO YOU SMOKE TOBACCO?** Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (eg, 2 cigars daily; pipe - 1 oz weekly)
14. TYPE OF LICENCE APPLIED FOR: State type of licence applied for from the following list: Aeroplane 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 And whether Fixed Wing / Rotary Wing / Both Other – Please specify	**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 (30) remarks box. 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. If information has been reported on a previous application form for a medical certificate and there has been no change in your condition, you may state 'Previously Reported; No Change Since'. However, you should still tick 'YES' to the condition. Do not report occasional common illnesses such as colds.
15. OCCUPATION: Indicate your principal employment.	
16. EMPLOYER: If principal occupation is pilot, then state employer's name or if self-employed, state 'self'.	**31. DECLARATION AND CONSENT TO OBTAINING AND RELEASING INFORMATION:** Do not sign or date these declarations until indicated to do so by the AME who will act as witness and sign accordingly.