

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Switzerland

Medical in Confidence

(1) State of licence issue:		(2) Class of medical certificate applied for: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> LAPL <input type="checkbox"/> Cabin Crew <input type="checkbox"/> 3 (ATC) <input type="checkbox"/> SRT <input type="checkbox"/> Others	
(3) Surname:		(4) Previous surname(s):	
(5) Forenames:		(6) Date of birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
(7) Sex:		(12) Application: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal/Revalidation	
(8) Place and country of birth:		(9) Nationality:	
(10) Permanent address: Country: Tel. No.: Mobile No.: Email:		(11) Postal address (if different): Country: Tel. No.:	
(18) Licence(s) held (type):		Licence number: Country of issue:	
(20) Have you ever had medical certificate denied, suspended or revoked by any licensing authority? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: Country: Details:		(13) System reference number:	
(24) Any aircraft accident or reported incident since last medical? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: Place: Details:		(14) Type of licence applied for:	
(27) Alcohol - state average weekly intake in units:		(15) Occupation (principal):	
(28) Do you currently use any medication <input type="checkbox"/> No <input type="checkbox"/> Yes State medication, dose, date started and why:		(16) Employer:	
(28b) Do you use any narcotics? <input type="checkbox"/> No <input type="checkbox"/> Yes		(17) Last medical examination: Date: Place:	
		(19) Any Conditions/ Limitations/ Variations on the Licence/ Medical Certificate: <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	
		(21) Total flight time: (22) Flight time since last medical:	
		(23) Aircraft presently flown:	
		(25) Type of flying intended:	
		(26) Present flying activity: <input type="checkbox"/> Single pilot <input type="checkbox"/> Multipilot Crew	
		(29) Do you smoke tobacco? <input type="checkbox"/> Never <input type="checkbox"/> No Date stopped: <input type="checkbox"/> Yes State type and amount: amount:	
		(29b) Do you smoke Marihuana or Hashish? <input type="checkbox"/> No <input type="checkbox"/> Yes	

General and 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 remarks section (30).

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

(30) Remarks:

Are there any changes since the last medical check? Yes No

(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 licencing 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 the licencing authority, 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 licencing authority, providing that I or my AME may have access to them according to national law. Medical Confidentiality will be respected at all times.

Date	Signature of applicant	Signature of AME / medical assessor	Examiner's Name and Address: Tel: Fax: AME No.:
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