SOUTH AFRICAN CIVIL AVIATION AUTHORITY
South Africa

South African Civil Aviation Authority

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Physical address: Ikhaya Lokundiza, 16 Treur Close, Waterfall Park, Bekker Street, Midrand, Gauteng
Postal address : Private Bag X73, Halfway House 1685

Medical in Confidence

(1) State applied to:

(2) Class of medical certificate applied for: ☐ 1 ☐ 2 ☐ 4 ☐ 3 ☐ Cabin Crew ☐ Others

(3) Surname:

(4) Previous surname(s):

(5) Forename(s):

(6) Date of birth: Id

(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: ☐ TWR ☐ APP ☐ ACC

(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	☐	☐
(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	☐	☐	(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 by applicant : I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete and correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statement in connection with this application, or if I do not consent to release the support, the supporting medical information, the Authority may refuse to grant me Medical Assessment or may withdraw any Medical Assessment granted, without prejudice to any other legal action applicable pursuant.

Consent to release of medical information: I hereby give my consent that all relevant medical information may be released and submitted to the Medical Assessor of the Licensing Authoritiy. Note: Medical Confidentiality will be respected all times.

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