

**Consent For CAA Aero Medical Examiner (AME) And Practice Staff  
To Access CAA Medical Records**

Applicant Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ CAA Licence/Reference No: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

AME Name: \_\_\_\_\_

AME Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

I give my consent for the AME above and his/her staff to access my relevant CAA medical records for the purposes of providing aeromedical advice, medical examinations or medical assessments.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please scan this form when signed with the photographic ID page of a passport, or UK driving licence in the area below and send via post our email to your AME.**

