

APPLICATION FORM FOR A LAPL MEDICAL CERTIFICATE

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: LAPL	
(3) Surname:		(4) Previous surname(s):	(12) Application: Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/>
(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:	(13) Reference number:
(10) Permanent address: Country: Telephone No.: Mobile No.: E-mail:		(11) Postal address (if different): Country: Telephone No.:	(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 <input type="checkbox"/> Yes <input type="checkbox"/> Details:	
(20) Have you ever had a medical certificate denied, suspended or 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 reported incident since 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, amount		(25) Type of flying intended:	
(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) Present flying activity: Single pilot <input type="checkbox"/> Multi pilot <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). If yes, give details in 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 disease			
102 Spectacles and/or contact lenses ever worn				113 Head injury or concussion				124 A positive HIV test				171 High blood pressure			
				114 Frequent or severe headaches				125 Sexually transmitted disease				172 High cholesterol level			
103 Spectacle/contact lens prescriptions change since last medical exam.				115 Dizziness or fainting spells				126 Sleep disorder/apnoea syndrome				173 Epilepsy			
				116 Unconsciousness for any reason				127 Musculoskeletal illness/impairment				174 Mental illness			
104 Hay fever, other allergy				117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.				128 Any other illness or injury				175 Diabetes			
105 Asthma, lung disease								129 Admission to hospital				176 Tuberculosis			
106 Heart or vascular trouble				118 Psychological/psychiatric trouble of any sort				128 130 Visit to medical practitioner since last medical examination				177 Allergy/asthma/eczema			
107 High or low blood pressure								129 131 Refusal of life insurance				178 Inherited disorders			
108 Kidney stone or blood in urine				119 Alcohol/drug/substance abuse				130 132 Refusal of flying licence				179 Glaucoma			
109 Diabetes, hormone disorder				120 Attempted suicide											
110 Stomach, liver or intestinal trouble				121 Motion sickness requiring medication				132 133 Medical rejection from or for military service				Females only:			
												150 Gynaecological, menstrual problems			
111 Deafness, ear disorder				122 Anaemia/sickle cell trait/other blood disorders				134 Award of pension or compensation for injury or illness				151 Are you pregnant?			

(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 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.

CONSENT TO RELEASE OF MEDICAL INFORMATION: Please read the statement below in relation to disclosure of information. The CAA 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 medicalweb@caa.co.uk.

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

My attention has been drawn to the CAA Medical Department's Fair Processing Notice which is published on the CAA's website."

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Date Signature of applicant Signature of GP GMC No

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FORM FOR A LAPL MEDICAL CERTIFICATE

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 this application is to be forwarded to.</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: Pre-completed</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, even if only temporary. If 'YES', state date (dd/mm/yyyy) and country where it occurred.</p>
<p>5. FORENAMES: 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. Cessna 150, sailplane etc.</p>
<p>8. PLACE AND COUNTRY OF BIRTH: State town and country of birth.</p>	<p>24. ANY AVIATION ACCIDENT OR REPORTED INCIDENT SINCE LAST MEDICAL EXAMINATION: If 'YES' box ticked, state date (dd/mm/yyyy) and country of accident/incident.</p>
<p>9. NATIONALITY: State name of country of citizenship.</p>	<p>25. TYPE OF FLYING INTENDED: eg recreational</p>
<p>10. PERMANENT ADDRESS: State permanent postal address and country. Enter telephone area code as well as telephone number.</p>	<p>26. PRESENT FLYING ACTIVITY: Tick appropriate box to indicate whether you fly as the SOLE pilot or not.</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? Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 litres 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. REFERENCE NUMBER: State reference number allocated to you by the competent authority (UK CAA) 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 LAPL licence applied for from the following list: Aeroplane Helicopter Sailplane Balloon</p>	<p>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 section. 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.</p>
<p>15. OCCUPATION (PRINCIPAL): Indicate your principal employment.</p>	
<p>16. EMPLOYER: If principal occupation is pilot, then state employer's name or if self-employed, state 'self'.</p>	