Reference:

CAR Part 67

Instructions:

(1) Complete this form fully using a black ballpoint pen and in block letters

(2) Medical confidentiality will be respected at all times.

(3) The making or causing to be made of fraudulent, misleading or intentionally false statement, for the purpose of obtaining a medical certificate constitutes an offence under Part XVI (283), of the PNG Civil Aviation Act 2000, and is subject, in the case of an individual, to imprisonment for a term not exceeding 12 months, or to a fine not exceeding K25,000 or both.

I apply to the Director of Civil Aviation for a Medical Certificate and hereby request a Designated Aviation Medical Examiner to examine me for that purpose.

MEDICAL IN CONFIDENCE

(1) Surname:	(2) Previous surname(s):	(3) National identification number (if applicable)	
(4) Forename(s):	(5) Date of birth:	(6) Sex	(7) Application
		☐ Male ☐ Female	☐ Initial ☐ Renewal
(8) Country of license issue:	(9) Class of Medical Assessment applied for:	(10) Type of license applied for (if initial application):	
	1st ☐ 2nd ☐ 3rd ☐ Other ☐		
(11) Place and country of birth:	(12) Nationality	(13) Occupation (principal):	
(14) Permanent address:	(15) Postal address (if different):	(16) Employer (principal):	
Postcode: Country: Telephone No: Mobile Cell No: Email:	Postcode: Country: Telephone No:		
(17) Last medical examiner	(18) Aviation license(s) held (type):	(19) Family physician's name and address:	
Date: Place:	License number(s): Country(ies) of issue:	Email: Telephone:	

(20) Any limitation on License/Medical Assessment?	(21) Have you ever had an aviation Medical Assessment denied, suspended or revoked by any licensing authority? If yes, discuss with medical examiner.	(22) Total flight time (hours):
Yes ☐ No ☐ Details:	Yes ☐ No ☐ Date: Details:	
(23) Flight time (hours) since last medical:	(24) Aircraft currently flown (e.g., Boeing 737, Cessna C150):	25) Any aircraft accident or reported incident since last medical?
		No ☐ Yes ☐ Date: Place:
(26) Type of flying intended (1) e.g., commercial air transport, flying instruction private:	(27) Type of flying intended (2):	(28) Do you drink alcohol beverages?
	☐ Single Crew ☐ multi-crew	☐ Yes ☐ No If YES, state average weekly intake in units:
(29) Do you smoke tobacco products?	(30) Do you currently use any medication, including non-prescribed medication?	
Never ☐ Previously ☐ Currently ☐ Date stopped: State type, amount and number of years:	Yes ☐ No ☐ If YES, state name of medication, date commenced, daily or weekly dose, and cause (diagnosis):	

(31) **General and medical history:** Do you have, or have you ever had, any of the following? YES or NO must be ticked after each question. Elaborate YES answers in the remarks section and discuss them with the medical examiner.

101 Eye disorder/eye surgery	☐ Yes ☐ No	112 Nose or throat disease or speech disorder	☐ Yes ☐ No	123 Malaria or other tropical disease	☐ Yes ☐ No	Family history of:	☐ Yes ☐ No
102 Spectacles and/or contact lenses ever worn	☐ Yes ☐ No	113 Head injury or concussion	☐ Yes ☐ No	124 A positive HIV test	☐ Yes ☐ No	140 heart disease	☐ Yes ☐ No
103 Spectacle/contact lens prescriptions/change since last medical exam	☐ Yes ☐ No	114 Frequent or severe headaches	☐ Yes ☐ No	125 Sexually transmitted disease	☐ Yes ☐ No	142 High cholesterol level	☐ Yes ☐ No
104 Hay fever, another allergy	☐ Yes ☐ No	115 Dizziness or fainting spells	☐ Yes ☐ No	126 Admission to hospital	☐ Yes ☐ No	143 Epilepsy	☐ Yes ☐ No

105 Asthma, lung disease	☐ Yes ☐ No	116 Unconsciousness for any reason	☐ Yes ☐ No	127 Any other illness or injury	☐ Yes ☐ No	144 Mental illness	☐ Yes ☐ No
106 Heart or vascular disease	☐ Yes ☐ No	117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc	☐ Yes ☐ No	128 Visit to medical practitioner since last medical examination	☐ Yes ☐ No	145 Diabetes	☐ Yes ☐ No
107 High or low blood pressure	☐ Yes ☐ No	118 Psychological/psychiatric trouble of any sort	☐ Yes ☐ No	129 Refusal of life insurance	☐ Yes ☐ No	146 Tuberculosis	☐ Yes ☐ No
108 Kidney stone or blood in urine	☐ Yes ☐ No	119 Alcohol/drug/substance abuse	☐ Yes ☐ No	130 Refusal of issue or revocation of aviation licence	☐ Yes ☐ No	147 Allergy/asthma/ecze ma	☐ Yes ☐ No
109 Diabetes, liver or intestinal trouble	☐ Yes ☐ No	120 Attempted suicides	☐ Yes ☐ No	131 Medical rejection from or for military service	☐ Yes ☐ No	148 Inherited disorders	☐ Yes ☐ No
110 Stomach, liver or intestinal trouble	☐ Yes ☐ No	121 Motion sickness requiring medication	☐ Yes ☐ No	132 Award of pension or compensation for injury or illness	☐ Yes ☐ No	149 Glaucoma **Females Only:**	☐ Yes ☐ No
111 Deafness, ear disease	☐ Yes ☐ No	122 Anaemia/Sickle cell trait/other blood disorders	☐ Yes ☐ No		☐ Yes ☐ No	150 Gynaecological disorders (including menstrual)	☐ Yes ☐ No
						151 Are you pregnant?	☐ Yes ☐ No

(152) **Remarks:** If previously reported and unchanged, so state:

(32) **DECLARATION:** 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 supporting medical information, the **Director** may refuse to grant me a Medical Certificate or may withdraw any Medical Certificate granted, without prejudice to any other legal action applicable pursuant to Section 64I of the PNG Civil Aviation Act 2000 as amended.

CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby give my consent that all relevant medical information may be released and submitted to the **Director**. I also consent to the disclosure to the **Director** and or his delegate, of any medical information relating to me, which is held by a registered medical practitioner, hospital or other organization. I understand that the **Director** may provide my personal relevant information to other international aviation jurisdiction for the purpose of aviation medical certification, as and when required.

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Date:	Signature of Applicant:	Signature of Medical Examiner: