༄༅། །འབྲུག་གི་ཞི་བའི་མཁའ་འགྲུལ་དབང་འཛིན།
གཞི་རྟེན་ཡོ་ཚས་དང་སྐྱེལ་འདྲེན་ལྷན་ཁག། དཔལ་ལྡན་འབྲུག་གཞུང་།
Bhutan Civil Aviation Authority
Ministry of Infrastructure & Transport
Royal Government of Bhutan

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Complete this page fully and in block capitals - Refer to instructions pages for details.

MEDICAL IN CONFIDENCE

(1) State of license issue:	(2) Medical certificate applied for: class 1 ☐ class 2 ☐		
(3) Surname:	(4) Previous surname(s):		(12) Application Initial ☐ Revalidation/Renewal ☐
(5) Fore names:	(6) Date of birth (dd/mm/yyyy):	(7) Sex Male ☐ Female ☐	(13) CID or Passport No :
(8) Place and country of birth:	(9) Nationality:		(14) Type of license applied for:
(10) Permanent address: Country: Telephone No.: Mobile No.: e-mail:	(11) Postal address (if different) Country: Telephone No.: (16) Employer (17) Last medical examination Date: Place:		(15) Occupation (principal)
(18) Aviation license(s) held (type): License number: State of issue:		(19) Any Limitations on License/ Medical Certificate No ☐ Yes ☐ Details:	
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? No ☐ Yes ☐ Date: Country: Details:		(21) Flight time hours total:	(22) Flight time hours since last medical:
	(23) Aircraft class /type(s) presently flown:		
(24) Any aviation accident or reported incident since last medical examination? No ☐ Yes ☐ Date: Place: Details:		(25) Type of flying intended:	
	(26) Present flying activity: Single pilot ☐ Multi pilot ☐		
(27) Do you drink alcohol? ☐ No ☐ Yes, amount		(28) Do you currently use any medication? No ☐ Yes ☐ State drug, dose, date started and why:	
(29) Do you smoke tobacco? ☐ No, never ☐ No, date stopped: ☐ Yes, state type and amount:			

༄༅། འབྲུག་མི་སྡེའི་མཁའ་འགྲུལ་དབང་འཛིན།
གཞི་རྟེན་ལས་ཚན་དང་སྒྲིལ་འདྲེན་ལྷན་ཁག། དཔལ་ལྡན་འབྲུག་གཞུང་།
Bhutan Civil Aviation Authority
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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 Spectacle/contact lens prescriptions change since last medical exam.			114 Frequent or severe headaches			125 Sexually transmitted disease			171 High blood pressure		
			115 Dizziness or fainting spells			126 Sleep disorder/ apnoea syndrome			172 High cholesterol level		
104 Hay fever, other allergy			116 Unconsciousness for any reason			127 Musculoskeletal illness/impairment			173 Epilepsy		
105 Asthma, lung disease			117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc			128 Any other illness or injury			174 Mental illness or suicide		
									175 Diabetes		
106 Heart or vascular trouble			118 Psychological/ psychiatric trouble of any sort			129 Admission to hospital			176 Tuberculosis		
									177 Allergy/ asthma/eczema		
107 High or low blood pressure			119 Alcohol/drug/ substance abuse			130 Visit to medical practitioner since last medical examination			178 Inherited disorders		
108 Kidney stone or blood in urine			120 Attempted suicide or self-harm			131 Refusal of life insurance			179 Glaucoma		
109 Diabetes, hormone disorder			121 Motion sickness requiring medication			132 Refusal of flying licence			**Females only:**		
110 Stomach, liver or intestinal trouble			122 Anaemia / Sickle cell trait/other blood disorders			133 Medical rejection from or for military service			150 Gynaecological, menstrual problems		
111 Deafness, ear disorder						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: 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 my licensing authority. Medical confidentiality will be respected at all times.

NOTIFICATION OF DISCLOSURE OF PERSONAL DATA: I hereby declare that I have been informed and I understand that the data contained in my medical certificate according to ARA.MED.130 may be electronically stored and made available to my AME in order to provide historical data required in BCAR.MED.A.035(b)(2)(ii)/(iii) and to the medical assessors of the competent authorities in order to facilitate the enforcement of ARA.MED.150(c)(4).

Date	Signature of applicant	Signature of AME/ (medical assessor)