SECTION:	LICENSING FORMS	LIF-MED-002
TITLE:	AVIATION MEDICAL CERTIFICATE APPLICATION FORM	

INSTRUCTION

Please complete this form, either electronically / type written or, write in Block Capitals using black or dark blue ink. Fill in the full name as it is shown in the passport. Put a tick (√) in the box for the appropriate option to choose. Failure to sign the form or to fill out the boxes and sections with correct information may result in delay or rejection of your application

FALSE REPRESENTATION STATEMENT

It is an offence under the law of Yemen to make, with intent to deceive, any false representation for the purpose of procuring the grant, issue, renewal or variation of any certificate, licence, approval, permission or other document. This offence is punishable with conviction by a fine or imprisonment or both.

1- APPLICATION TYPE

❑ INITIAL ❑ RENEWAL

CAMA LICENSE NO (if any): _____

CLASS OF MEDICAL CERTIFICATE APPLIED FOR: ❑ CLASS 1 ❑ CLASS 2 ❑ CLASS 3

CAMA LICENSE TYPE APPLIED/HELD: ❑ SPL ❑ PPL ❑ CPL ❑ ATPL ❑ FE ❑ CC ❑ ATC

FIRST NAME: _____MID NAME: _____LAST NAME: _____

DATE OF BIRTH (DD/MM/YYYY): _____AGE: _____

NATIONALITY: _____ SEX: ❑ Male ❑ Female

OFFICE NO: _____MOBILE NO: _____E-MAIL: _____

ADDRESS: _____CAMA File No (if available): _____

EMPLOYER: _____OCCUPATION: _____

2- AVIATION LICENSE(S) HELD

❑ SPL ❑ PPL ❑ CPL ❑ ATPL ❑ FE ❑ CC ❑ ATC

LICENSE NO: _____COUNTRY OF ISSUE: _____

ANY CONDITION / LIMITATION OR VARIATION ON THE LICENSE / MEDICAL CERTIFICATE

❑ YES ❑ NO IF YES GIVE DETAILS: _____

3- LAST MEDICAL EXAMINATION

DATE: _____PLACE: _____

AME ADDRESS: _____ AME TELEPHONE NO: _____

4- FLYING INFORMATION

TOTAL FLYING HOURS: _____

TOTAL FLYING HOURS SINCE LAST MEDICAL: _____

AIRCRAFT PRESENTLY FLOWN: _____TYPE OF FLYING INTENDED_____

PRESENT FLYING ACTIVITY: ❑ SINGLE PILOT ❑ MULTI PILOT

OTHER AVIATION LICENSE/S HELD: LICENSE NO: _____COUNTRY: _____

HAVE YOU EVER HAD AN AVIATION MEDICAL CERTIFICATE DENIED, LIMITED, SUSPENDED OR REVOKED BY ANY LICENSING AUTHORITY? ❑ NO

❑ YES

DATE: _____DETAILS: _____

ANY AIRCRAFT ACCIDENT OR REPORTED INCIDENCE SINCE LAST MEDICAL? ❑ NO

❑ YES

DATE: _____ PLACE: _____

DETAILS: _____

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5- PERSONAL INFORMATION

DO YOU CONSUME ANY ALCOHOL? ❑ NO
❑ YES DRINKS PER WEEK: _____

DO YOU SMOKE INCUDING SHEESHA? ❑ NO
❑ PREVIOUSLY YEAR STOPPED: _____
❑ YES TYPE: ❑ CIGARETTE ❑ CIGAR ❑ PIPE ❑ HISHA
AMOUNT (Cig/Day): _____

DO YOU CURRENTLY USE ANY MEDICATION (INCLUDING OVER THE COUNTER MEDICINES AND VITAMINS)? ❑ NO
❑ YES Name of Drugs: _____Date started, Dose: _____
Reason for starting: _____

6- GENERAL MEDICAL HISTORY

DO YOU HAVE OR HAD ANY OF THE FOLLOWING (PLEASE TICK THE APPROPRIATE RESPONSE): NOTE: IF VALIDATING AT THE SAME VENUE AS LAST EXAMINATION, TICK ONLY BOXES RELATING TO ANY MEDICAL/SURGICAL/OPHTHALMIC OR OTHER EVENTS OR CHANGES SINCE LAST EXAMINED. IF NO CHANGE, STATE THIS IN REMARKS.

	HAVE YOU EVER HAD	YES	NO	REMARKS
1	ANY EYE OPERATION/SPECTACLES/CONTACT LENSES OR CHANGE IN PRESCRIPTION SINCE LAST MEDICAL			
2	ASTHMA / HAY FEVER / LUNG DISEASE / ALLERGIES / RESPIRATORY PROBLEMS			
3	COUGHING UP BLOOD			
4	CHEST OR ABDOMINAL PAIN			
5	VOMITING BLOOD			
6	STOMACH PAINS OR BOWEL PROBLEMS INCLUDING INDIGESTION			
7	BLOOD IN URINE OR FAECES			
8	HEART OR VASCULAR PROBLEMS OF ANY KIND			
9	HIGH OR LOW BLOOD PRESSURE			
10	HIGH CHOLESTEROL			
11	DIABETES, IMPARED GLUCOSE REGULATION OR ANY OTHER ENDOCRINE CONDITION			
12	KIDNEY OR BLADDER CONDITION INCLUDING STONES			
13	EAR OR HEARING PROBLEM INCLUDING TINNITIS			
14	NOSE, THROAT, SINUS OR SPEECH DISORDER			
15	SNORING OR ANY CONDITION AFFECTING YOUR ABILITY TO SLEEP			
16	HEAD INJURY OR CONCUSSION			
17	FREQUENT HEADACHES OR MIGRAINE			
18	DIZZINESS/FAINTING SPELLS/BLACK OUTS/ LOSS OF CONSCIOUSNESS FOR ANY REASON			
19	FITS, SEIZURES, CONVULSIONS OR EPILEPSY			
20	ANY STROKE/PARALYSIS			
21	ANY MENTAL ILLNESS; DEPRESSION / SUCIDAL ATTEMPT / PHOBIA / ANXIETY / ALCOHOL OR DRUG ABUSE PROBLEMS			
22	EATING DISORDERS INCLUDING ANOREXIA OR BULIMIA			
23	MOTION SICKNESS REQUIRING TREATMENT			
24	ANEMIA/SICKLE CELL TRAIT/OTHER BLOOD DISORDER			
25	DEN GUE FEVER/ MALARIA OR OTHER TROPICAL DISEASES			
26	TUBERCULOSIS (TB)			
27	HIV OR HEPATITIS OF ANY TYPE			
28	SKIN DISEASES			
29	SURGICAL OPERATIONS OF ANY KIND			
30	GROWTHS, TUMORS OR MALIGNANCIES			

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GENERAL MEDICAL HISTORY (CONTINUED) DECLARATION				
	HAVE YOU EVER HAD	**YES**	**NO**	**REMARKS**
31	SUSTAINED ANY SERIOUS INJURY E.G. FRACTURE, DISLOCATION RESULTING IN ONGOING PROBLEMS			
32	ANY VISIT TO MEDICAL PRACTITIONER SINCE LAST MEDICAL EXAMINATION/HOSPITAL ADMISSION			
33	ANY ILLNESS WHICH NEEDED MORE THAN 20 DAYS OFF CONTINUOUSLY			
34	FOR FEMALES. ANY GYNAECOLOGICAL OR MENSTRUAL DISORDER/PREGNANCY			
35	FAMILY HISTORY OF DIABETES / HYPERTENSION / CANCER / HIGH CHOLESTEROL / HEART DISEASE / EPILEPSY / TB / ALLERGY /ASTHMA / INHERITEDDISORDER / GLAUCOMA			
36	MUSCULOSKELETAL CONDITIONS			
37	REFUSAL OF LIFE INSURANCE			
38	REFUSAL OF FLYING LICENSE			
39	MEDICAL REJECTION FROM OR FOR MILITARY SERVICE			
40	AWARD OF PENSION OR COMPENSATION FOR INJURY OR ILLNESS			
41	HAVE YOU EVER BEEN CHARGED OR CONVICTED WITH OFFENCES RELATED TO DRUGS OR ALCOHOL			
42	ANY MENTAL OR PHYSICAL ILLNESS NOT MENTIONED ABOVE			

7- DECLARATION

I hereby declare that I have carefully considered the statements made above and that to the best of my knowledge 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, I may be guilty of a criminal offence and the CAMA may refuse to grant me a medical certificate or withdraw any medical certificate granted.

CONSENT TO OBTAINING MEDICAL INFORMATION:

I hereby authorize the release of all information contained in this report or any or all attachments to the CAMA, recognizing that these documents are to be used for completion of a medical assessment and will become the property of the CAMA, providing that I or my AME may request them if necessary. Medical confidentiality will be respected at all time.

DATE: _____ SIGNATURE OF APPLICANT: _____

SIGNATURE OF AME: _____

8- VITAL SIGNS

HEIGHT (m): _____B. M. I: _____NECK SIZE (cm): _____

WAIST CIRCUMFERENCE (cm): _____BLOOD PRESSURE (mmHg): _____

PULSE (Rate/Rhythm): _____EYE COLOR: _____

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9- GENERAL CLINICAL EXAMINATION

PLEASE MARK YOUR CLINICAL EXAMINATION FINDINGS AS "NORMAL" OR "ABNORMAL". ELABORATE THE ABNORMAL FINDINGS IN THE REMARKS BOX BELOW. USE ADDITIONAL SHEETS IF NECESSARY.

S. No.	SYSTEM	NORMAL	ABNORMAL
1	HEAD, FACE, NECK, SCALP		
2	MOUTH, THROAT, TEETH		
3	NOSE, SINUSES		
4	EARS, DRUMS, EARDRUM MOTILITY		
5	EYES - ORBIT, ADENXA; VISUAL FEILDS		
6	EYES - PUPILS, OPTIC FUNDI		
7	EYES - OCULAR MOTILITY, NYSTAGMUS		
8	LUNG, CHEST, BREAST - IF APPLICABLE		
9	HEART AND VASCULAR SYSTEM		
10	ABDOMEN, HERNIA, LIVER, SPLEEN		
11	ANUS, RECTUM (IF REQUIRED)		
12	GENITOURINARY SYSTEM INCLUDING TESTES		
13	ENDOCRINE SYSTEM		
14	UPPER AND LOWER LIMBS, JOINTS		
15	SPINE AND OTHER MUSCULOSKELETAL		
16	NEUROLOGIC - REFLEXES, ETC.		
17	PSYCHIATRIC		
18	SKIN, IDENTIFYING MARKS AND LYMPHATICS		
19	GENERAL SYSTEMIC		

REMARKS:

10- VISUAL ACUITY EXAMINATION AND CONVERSATIONAL TEST

	NEAR VISUAL ACUITY N5 AT 30 - 50 cm		INTERMEDIATE VISION N14 AT 100 cm		DISTANT VISION 6 m	
	UNCORRECTED	CORRECTED	UNCORRECTED	CORRECTED	UNCORRECTED	CORRECTED
RIGHT EYE	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
LEFT EYE	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
BOTH EYES	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

COLOUR VISION (PSEUDOCHROMATIC PLATE):

TYPE: _____NO. OF PLATES: _____ NO. OF ERRORS: _____

GLASSES: ❑ NO ❑ YES TYPE: _____

CONTACT LENSES: ❑ NO ❑ YES TYPE: _____

CONVERSATIONAL TEST AT 2 m, BACK TURNED TO EXAMINER:

RIGHT EAR: ❑ NORMAL ❑ ABNORMAL

CONTACT LENSES: ❑ NORMAL ❑ ABNORMAL

REMARKS: _____ **REMARKS:** _____

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11- ACCOMPANYING REPORTS

	NORMAL	ABNORMAL	REMARKS
ECG			
AUDIOGRAM			
OPHTHALMOLOGY REPORT			
ENT REPORT			
CHEST X RAY			
PULMONARY FUNCTION TEST			
HEMOGLOBIN			
RESULT OF DRUG TESTS			
BLOOD LIPIDS			
BLOOD GLUCOSE			
CV RISK ASSESSMENT (TYPE, %)			
OTHERS			

URINALYSIS: GLUCOSE: _____KETONE: _____
PROTIENS: _____BLOOD: _____

❑ NORMAL ❑ ABNORMAL

12- AVIATION MEDICAL EXAMINER RECOMMENDATIONS

❑ FIT
❑ UNFIT
❑ COMMENTS, RESTRICTION, LIMITATIONS
❑ DEFFERRED FOR FURTHER EVALUATION. IF YES WHY AND TO WHOM?

CLASS:
❑ 1
❑ 2
❑ 3

REMARKS:

NURSE NAME: _____ SIGNATURE_____

AME NAME: _____ **DESIG. NO.: _____** **ADDRESS: _____**

AME SIGNATURE | AME STAMP

DATE OF ISSUANCE OF MEDICAL CERTIFICATE TO THE CANDIDATE: _____

13- CAMA ACTION
(For CAMA Use Only)

13-1 AEROMEDICAL INSPECTOR ASSIGNED TO THIS APPLICATION

❑ **FORWARD** ❑ **REQUEST MORE INFORMATION** ❑ **REJECT** ❑ **APPROVE**

REMARKS:

NAME OF AEROMEDICAL INSPECTOR: _____
SIGNATURE: _____ DATE: _____

13-2 AEROMEDICAL MANAGER / D.G. OF PEL & EXAMINATION

❑ **REJECT** ❑ **APPROVE**

NAME OF AEROMEDICAL MANAGER / D.G. OF PEL & EXAMINATION: _____
SIGNATURE: _____ DATE: _____

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CHECKLIST FOR CAMA MEDICAL CERTIFICATE APPLICATION

A- INITIAL ISSUE OF YCAMA MEDICAL CERTIFICATE:

1. Cover letter from the clinic or AME
2. Completed CAMA Med Form (02 & 03)
3. One colour photo 3.0 x 3.5 cm (Blue background)
4. Eye extended test report (Not required for Cabin Crew)
5. Chest X-Ray report
6. Original ECG tracing with report (Not required for Cabin Crew under age 40)
7. Original Audiometry tracing with report (Not required for Cabin Crew unless hearing loss suspected)
8. Drug Screening report
9. letter from the employer for CPL/ATPL students (not required for Yemeni nationals)
10. Applicable fee in cash

B- RENEWAL OF YCAMA MEDICAL CERTIFICATE:

1. Cover letter from the clinic or AME
2. Completed CAMA Med Form (02 & 03)
3. One colour photo 3.0 x 3.5 cm (Blue background)
4. Copy of previous Medical Card
5. Copy of the Medical Certificate (If issued)
6. Chest X-Ray report (if required)
7. ECG original tracing with report (When test is due)
8. Audiometry original tracing with report (When test is due)
9. Applicable fee in cash

C- RE-ISSUANCE OF YCAMA MEDICAL CERTIFICATE (LOST OR DAMAGED):

1. Employer / Applicant request letter
2. Copy of previous Medical Certificate
3. Applicable licensing fee in cash

D- CHANGE OF CANDIDATE INFORMATION ON YCAMA MEDICAL CERTIFICATE:

1. Employer / Applicant request letter
2. Copy of Medical Certificate
3. Copy of ID / Passport
4. Applicable fee in cash