SOUTH AFRICAN CIVIL AVIATION AUTHORITY

Section/division **AVMED**
Telephone number: **011-545-1000** *Fax Number:* **011 545-1457**
Physical address **Ikhaya Lokundiza, 16 Treur Close, Waterfall Park, Bekker Street, Midrand, Gauteng**
Postal address: **Private Bag X73, Halfway House 1685** *Website:* **www.caa.co.za**

Form Number: CA 67-02(a)

AVIATION MEDICAL REPORT

PERSONAL INFORMATION

1. Name:	Surname		First name(s)	
2. Postal address				
			Postal code	

3. Telephone numbers	During office hours	After hours	Cellular

4. Date of birth (dd/mm/yyyy)		5. Eye colour	
6. Hair colour		7. Gender	
8. Nationality		9. Occupation	

FLIGHT MEDICAL INFORMATION

1. Identity/ passport number		2. Licence number	
3. Medical class applied for		4. Licence type	

5. Flight time			6. Type of flying intended			7. Previous medical examination	
Last 6 months	Last 12 months	Total	Recreation	Business	Career	Doctor	Date

Previous restrictions/ protocols	Medication used previous 3 months: (name and dosage)

SANDF	1. Number	2. Rank	3.Previous medical classification	4. Arm of service, unit, station

MEDICAL HISTORY

Kindly mark the applicable block. If yes please provide complete details below. If the space is insufficient, add supplementary notes on separate sheet.

Family history	**Y**	**N**		**Y**	**N**		**Y**	**N**
1. Heart disease or high blood pressure			13. Dizziness or unsteadiness			28. Heart murmur / valve problem		
2. Epilepsy or convulsions			14. Unconsciousness (for any reason)			29 Any blood or thyroid disorder		
3. Glaucoma or blindness			15. Head injury or concussion			30. Heartburn/ frequent indigestion		
4. Diabetes/sugar sickness			16. Epilepsy or fits of any kind			31. Stomach, liver / intestine problem		
5. Mental illness			17. Any other neurological disorder			32. Bleeding from the rectum		
Have you ever been			18. Any mental/psychological disorder			33. Kidney stone/ blood in urine		
6. Refused insurance on medical grounds			19. Suicide attempt			34. Sugar or protein in the urine		
7. Refused a flying licence, or grounded			20. Eye or vision trouble other than specs			35. Diabetes (sugar sickness)		
8. Convicted of a civil / criminal offence			21. Motion sickness requiring treatment			36. Muscle, bone or joint problems		
9. Medically rejected for military service			22. Hearing or speech disorders			37. Prostate/ Gynaecological problems		
Since your last medical, have you been			23. Hay fever or allergy			38. STD, excluding HIV		
10. Admitted to hospital			24. Asthma or lung disease			39. Malignant tumour or cancer		
11. Involved in a vehicle/aircraft accident			25. Tuberculosis or pneumonia			40. Weight loss (without dieting)		
Have you ever had / do you now have			26. Heart disease or high blood pressure			41. Malaria/ other tropical disease		
12. Frequent or severe headaches			27. Chest discomfort, pain / palpitations			42. Any other illness or injury		

Safety promotion – please state							
43. Number of cigarettes smoked daily		46. Type and number of alcoholic drinks used weekly					
44. Number of years that you have smoked		47. Drugs or other substances previously used					
45. Date that you stopped smoking		48. Whether you have had a blood test for HIV (no need to provide the result of the test)	**Y**		**N**		

REMARKS

Aviation Medical Examiner to comment in full on all items marked YES. Please attach additional pages if space is insufficient

MEDICAL TREATMENT SINCE LAST EXAMINATION

Date of medical treatment	
Name of medical practitioner	
Diagnosis/ reason for treatment	

NOTICE

Any person who makes, either orally or in writing, a false or misleading statement in or in connection with any application for a licence, certificate or rating issued under these regulations or any return furnished in accordance with any requirement of these regulations, shall be guilty of an offence. (Civil Aviation Regulations (CAR), Part 185.001.1 (1) (di – dii)

DECLARATION BY APPLICANT

I hereby certify that all statements made by me in this examination form are complete and true, to the best of my knowledge, and I hereby agree –

- That they are to be considered part of the basis of issuance of any medical certificate to me; and
- That all medical records must be released to the CCA or appointed delegate if so requested by the CCA.

SIGNATURE OF APPLICANT	**NAME IN BLOCK LETTERS**	**DATE**
SIGNATURE OF AME (AS WITNESS)	**NAME IN BLOCK LETTERS**	**DATE**

PHYSICAL EXAMINATION

1. Mass		2. Height	
3. BMI		4. Pulse	
5. Blood pressure (sitting)			

		pH	Sugar	Protein	Appearance	Blood
6. Urinalysis	**Normal**					
	Abnormal					

Mark appropriate column	N	ABN	Mark appropriate column	N	ABN	Mark appropriate column	N	ABN
7. Head, face, scalp and neck			13. Heart			19. Lower limbs		
8. Nose and sinuses			14. Vascular & lymphatics			20. Spine & musculo-skeletal		
9. Ears and eardrums			15. Abdomen			21. Skin		
10. Valsalva (patent bilaterally)			16. Genito-urinary system			22. Identifying body marks		
11. Romberg			17. Neurological system			23. Psychological evaluation		
12. Lungs, chest and breast			18. Upper limbs			24. Any other problems		

DESCRIPTION OF FINDINGS (*Describe every abnormality in detail. Attach additional pages, if necessary.)*

VISUAL EXAMINATION

History	Y	N	10. Distance vision			11. Intermediate vision		12. Near vision	
1. Exam performed by AME				Uncorrected	Corrected	Uncorrected	Corrected	Uncorrected	Corrected
2. Spectacles used regularly			Both						
3. Contact lenses used regularly			Right						
Examination			Left						
4. Orbit and adnexae			13. Phorias			14. Colour vision			
5. Eye movements			Distance vertical			Test used	Number of plates	Number correct	
6. Visual fields			Distance horizontal						
7. Near point of convergence			Near vertical			Lantern test previously performed? State date and result			
8. Pupils			Near horizontal						
9. Fundoscopy			15. Previous eye surgery performed – state date and procedure						

AUDIOGRAM (dB hearing loss)

	250	500	1000	2000	3000	4000	6000
Right							
Left							

ANY OTHER TESTS PERFORMED Type and result

SPECIAL INVESTIGATIONS

	Date performed	Result	Next due
1. Resting ECG			
2. Stress-ECG			
3. Lung function test			
4. Lipogram			
5. Chest X-ray			

CVD RISK FACTOR ASSESSMENT

Item	Y	N	Item	Y	N
(+) Family history			Obesity		
Age and gender			Hypertension		
Smoking			High cholesterol		
Exercise			Diabetes		

Comments

SUMMARY OF FINDINGS

Significant history:

Abnormal findings:

Additional reports required:

AVIATION MEDICAL EXAMINER ASSESSMENT AND DECLARATION

I hereby certify that I have personally reviewed the medical history and personally examined the applicant named in this report. This report and attachments embody my findings completely and correctly.

Recommendation		**Dates**		**Restrictions/comments**
Fit		From		
Temporary unfit				
Class		To		
Licence type				

SIGNATURE OF EXAMINER	**NAME IN BLOCK LETTERS**	**DATE**

EXAMINER'S CODE	
EXAMINER'S TELEPHONE NUMBER	
EXAMINER'S ADDRESS	

FOR OFFICE USE ONLY

This certifies that the applicant is	

Recommendation		**Dates**		**Restrictions/comments**
Fit		From		
Temporary unfit				
Class		To		
Licence type				

SIGNATURE OF EXAMINER	**NAME IN BLOCK LETTERS**	**DATE**

EXAMINER'S CODE	
EXAMINER'S TELEPHONE NUMBER	
EXAMINER'S ADDRESS	