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Transport Canada Transports Canada

PROTECTED WHEN COMPLETED

CIVIL AVIATION MEDICAL EXAMINATION REPORT

Region

File number **5802** -

PART A (TO BE COMPLETED BY APPLICANT)

Type of Permit / Licence desired (If A.T.C. state position)	Aviation Permit / Licence held (Type)	Permit / Licence Number	Telephone number: Home	Business

Given names	Family name	Former surname

Address (Number, street, apt)	City, Province	Country of residence	Postal code

Has your mailing address changed since your last medical? ☐ Yes ☐ No	Date of birth (yyyy-mm-dd)	Place of birth (Country)	☐ Male ☐ Female	Citizen of (Country)	Education

Occupation	Employer	PILOT FLIGHT TIME	Last 90 days	Last 12 months	Total

Have you had an aircraft accident since your last civil aviation medical examination? ☐ Yes ☐ No Date (yyyy-mm-dd)	Place	Aircraft Registration Marks

Have you consulted a physician since your last aviation medical examination? If yes, give reason.	Have you ever been refused issue or renewal of a Civil Aviation Licence for medical reasons? ☐ Yes ☐ No	Date of last Audiogram (yyyy-mm-dd)
	Are you receiving a pension or compensation for injury? ☐ Yes ☐ No	Date of last E.C.G. (yyyy-mm-dd)
	Last Civil Aviation Medical Examiniation Date (yyyy-mm-dd)	Place (City, Province) or Country

Primary Type of flying intended	Language of Aeronautical Publications
☐ Recreation ☐ Business ☐ Career	☐ English ☐ French

PART B (TO BE COMPLETED BY EXAMINER)

Is there a family history of:	Yes	No
1. Mental illness	☐	☐
2. Cardiovascular disease or hypertension	☐	☐
3. Diabetes	☐	☐
	☐	☐

Details - To be completed by Medical Examiner

C.V. risk factors
Examiner please check (✔)

Family history	☐	Smoking	☐
Hypertension	☐	Diabetes	☐
Obesity	☐	Serum Lipids	☐

REVIEW OF SYSTEMS

Has the applicant ever had or been treated for any of the following conditions?

	Yes	No		Yes	No
1. Head injury, dizziness, loss of consciousness	☐	☐	9. Gastrointestinal disorders	☐	☐
2. Frequent or severe headaches	☐	☐	10. Musculo - skeletal disorders	☐	☐
3. Epilepsy	☐	☐	11. Menstrual disorders	☐	☐
4. Psychiatric/neurological problems	☐	☐	12. Alcohol or substance abuse	☐	☐
5. Ear disease or deafness	☐	☐	13. Any other medical conditions	☐	☐
6. Allergies	☐	☐	14. Current medications (Prescriptions or OTC)	☐	☐
7. Pulmonary disorders including asthma	☐	☐	15. Does the applicant smoke more than 5 cigarettes per day?	☐	☐
8. Cardiovascular disorders including hypertension	☐	☐	16. Weekly alcohol intake (units)	☐	☐

Examiner please elaborate

List injuries, operations, serious illnesses and dates

STATEMENT OF APPLICANT

I hereby declare that I have read and understood the above information which to the best of my knowledge is complete and correct. I recognize that this report and any other medical documentation submitted or authorized to be submitted by me as part of my application for licence or permit is the property of Transport Canada Civil Aviation Medical Advisors.

I authorize the release of any information contained herein or in other relevant medical reports, including electrocardiograms, audiograms, specialist reports and other relevant medical information to Transport Canada, Civil Aviation Medicine Branch, for the sole purpose of establishing my medical fitness to hold a licence or permit issued by Transport Canada. I am aware that it is an offence under the *Aeronautics Act* to knowingly make a false declaration.

Date (yyyy-mm-dd / aaaa-mm-jj) | Applicant's Signature | Witness

PART D: CIVIL AVIATION MEDICAL EXAMINER'S RECOMMENDATION (TO BE COMPLETED AFTER MEDICAL EXAMINATION)

RECOMMENDATION

Please tick (✔) ☐ Fit ☐ Deferred

Category ☐ 1 ☐ 2 ☐ 3 ☐ 4

Remarks

	Yes	No
Was a renewal assigned?	☐	☐
Do you recommend further examination?	☐	☐
Are you sending a separate confidential report?	☐	☐
Has the last renewal box on the medical certificate been used?	☐	☐

CAME Stamp

Date (yyyy-mm-dd) | Telephone | CAME Signature

Canada

PART C: (TO BE COMPLETED BY EXAMINER)

Name	Licence No.

PHYSICAL EXAMINATION

Height cm	Weight kg	Colour of hair	Colour of eyes	Blood pressure(s)	Identifying marks

Check each item	Norm	Abnor	Elaborate on each abnormal response with diagnosis if possible
1. Nutrition	☐	☐	
2. Nose and throat	☐	☐	
3. Ears	☐	☐	
4. Respiratory system	☐	☐	
5. Cardiovascular	☐	☐	
6. Gastro intestinal	☐	☐	
7. Genito-urinary	☐	☐	
8. Locomotor	☐	☐	
9. Neurological	☐	☐	
10. Mental status	☐	☐	
11. Integument	☐	☐	

VISUAL EXAMINATION

	ACUITY	Glasses	Contact lenses
Distant	Right eye / Corrected to	/	/
	Left eye / Corrected to	/	/
	Both eyes / Corrected to	/	/

	Normal	Abnormal
Optic fundi		
Visual fields		

Near (N5 @ 30-50 cm)	Uncorrected Yes	Uncorrected No	Corrected Yes	Corrected No
Right eye	☐	☐	☐	☐
Left eye	☐	☐	☐	☐

OCULAR MUSCLE BALANCE

Ortho _____	Eso _____ △
Hyper _____ △	Exo _____ △
Cover Test	

Lens Prescription	Sphere	Cylinder
Right		
Left		

	Yes	No
Do you recommend an eye specialist examination?	☐	☐

COLOUR PERCEPTION EXAMINATION

Pseudoisochromatic Plates	Type	Number of plates	Number of errors

HEARING EXAMINATION

Whispered voice (Record distance in meters)

Right _____

Left _____

AUDIOGRAM / AUDIOSCOPE (if applicable)

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

URINALYSIS

Glucose	Other

OTHER TESTS, COMMENTS, ETC.

RAMO ASSESSMENT (DEPARTMENTAL USE ONLY)

Comments / Restrictions

		P	V	C	H
1st Category ☐	Suffix				
	Code(s)				
		P	V	C	H
2nd Category ☐	Suffix				
	Code(s)				

Path Code(s) ☐ ☐

Date (yyyy-mm-dd)

RAMO Signature _____

DAPLS

Entered in CAMIS	Date (yyyy-mm-dd)