Reset

TRAFICOM
Finnish Transport and Communications Agency

Application form for medical certificate
FINLAND

Please use block letters. See separate instructions.

MEDICAL IN CONFIDENCE

(1) State of licence issue:	(2) Class of medical certificate applied for:	☐ Class 1 ☐ LAPL ☐ Cabin crew ☐ Class 2 ☐ Class 3
(3) Surname:	(4) Previous surname(s):	(12) Application: ☐ Initial ☐ Renewal / Revalidation
(5) Forenames:	(6) Date of birth: (7) Sex ☐ Male ☐ Female	(13) Reference number:
(8) Place and country of birth:	(9) Nationality:	(14) Type of licence applied for:
(10) Permanent address: Country: Telephone No: E-mail:	(11) Postal address (if different): Country: Telephone No:	(15) Occupation (principal): (16) Employer: (17) Last medical examination: Date: Place:
(18) Aviation licence(s) held (type):	Licence number: / State of issue:	(19) Any limitations on the licence / medical certificate: ☐ No ☐ Yes. Details:
(20) Have you ever had an aviation medical certicate denied, suspended or revoked by any licensing authority? ☐ No ☐ Yes. Details: Date: Place:		(21) Flight time total / (22) Flight time since last medical: (23) Aircraft class/type(s) presently flown:
(24) Any aviation accident or reported incident since last medical examination? ☐ No ☐ Yes. Details: Date: Place:		(25) Type of flying intended: If flying single pilot commercial flights please mark ☐ PAX for remuneration ☐ PAX not for remuneration (26) Present flying activity ☐ Single pilot ☐ Multi pilot
(27) Alcohol - state average weekly intake in units:		Current ATCO activity ☐ ADI ☐ APS ☐ ACS
(28) Do you currently use any medication? ☐ No ☐ Yes State medication, dose, date started and why:	(29) Do you smoke tobacco? ☐ No ☐ Date stopped: ☐ Yes. State type and amount:	

General and medical history: Do you have, or have you ever had, any of the following? (Please tick).
Note: If yes, give details in remarks section (30.)

	Yes	No		Yes	No		Yes	No
101 Eye trouble/eye operation	☐	☐	117 Neurological disorders: stroke, epilepsy, seizure, paralysis, etc.	☐	☐	133 Medical rejection from or for military service	☐	☐
102 Spectacles and/or contact lenses ever worn	☐	☐	118 Psychological/psychiatric trouble of any sort	☐	☐	134 Award of pension or compensation for injury or illness	☐	☐
103 Spectacle/contact lens prescriptions change since last medical exam	☐	☐	119 Alcohol/drug/substance abuse	☐	☐	**Females only:**		
104 Hay fever, other allergy	☐	☐	120 Attempted suicide or self-harm	☐	☐	150 Gynaecological, menstrual problems	☐	☐
105 Asthma, lung disease	☐	☐	121 Motion sickness requiring medication	☐	☐	151 Are you pregnant	☐	☐
106 Heart or vascular trouble	☐	☐	122 Anaemia/Sickle cell trait / other blood disorders	☐	☐	**Family history of:**		
107 High or low blood pressure	☐	☐	123 Malaria or other tropical disease	☐	☐	170 Heart disease	☐	☐
108 Kidney stone or blood in urine	☐	☐	124 A positive HIV test	☐	☐	171 High blood pressure	☐	☐
109 Diabetes, hormone disorder	☐	☐	125 Sexually transmitted disease	☐	☐	172 High cholesterol level	☐	☐
110 Stomach, liver or intestinal trouble	☐	☐	126 Sleep disorder/apnoea syndrome	☐	☐	173 Epilepsy	☐	☐
111 Deafness, ear disorder	☐	☐	127 Musculoskeletal illness/impairment	☐	☐	174 Mental illness or suicide	☐	☐
112 Nose, throat or speech disorder	☐	☐	128 Any other illness or injury	☐	☐	175 Diabetes	☐	☐
113 Head injury or concussion	☐	☐	129 Admission to hospital	☐	☐	176 Tuberculosis	☐	☐
114 Frequent or severe headaches	☐	☐	130 Visit to medical practioner since last medical examination	☐	☐	177 Allergy / asthma / eczema	☐	☐
115 Dizziness or fainting spells	☐	☐	131 Refusal of life insurance	☐	☐	178 Inherited disorders	☐	☐
116 Unconsciousness for any reason	☐	☐	132 Refusal of flying licence	☐	☐	179 Glaucoma	☐	☐

(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 my licensing authority , to the medical assessor of the competent authority of my AME and to relevant medical professionals for the purpose of completion of an aero-medical assessment or a secondary review, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. 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 MED.A.035(b)(2)(ii)/(iii) and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of ARA.MED.150(c)(4).

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

Finnish Transport and Communications Agency, PO Box 320, FI-00059 TRAFICOM, Finland • Business ID 2924753-3 • www.traficom.fi

Print

Instructions for completion of the application form for aviation medical certificate

Please send this application form and any accompanying report forms and reports to the aviation authority (AMS). Medical confidentiality shall be respected at all times.

The applicant must carefully fill in all boxes of the application form. Type the answers and print three identical copies of the form. Clear the form after printing. If more space is required to answer any question, write on a plain sheet of paper the applicant's name, the information, your signature and the date signed. The following instructions apply to the same numbered headings on the application form.

NOTICE: Failure to complete the medical examination report form in full as required or to write legibly may result in non acceptance of the application in total and may lead to withdrawal of any medical certificate issued. The making of false or misleading statements or the withholding of relevant information by the applicant may result in criminal prosecution, denial of an application or withdrawal of any medical certificate granted.

1. STATE OF LICENCE ISSUE:
State name of country this application is to be forwarded to.

2. CLASS OF MEDICAL CERTIFICATE:
Tick appropriate box.
Class 1: Professional pilot
Class 2: Private pilot
LAPL
Class 3: Air traffic controllers and flight information service officers
Class 4: National - ultralight pilot, autogyro pilot
Cabin crew member

3. SURNAME:
State surname / family name.

4. PREVIOUS SURNAME(S):
If your surname or family name has changed for any reason, state previous name(s).

5. FORENAMES:
State first and middle names (maximum three).

6. DATE OF BIRTH:
Specify in order day(DD), month(MM), year(YYYY) in numerals, e.g. 22-08-1950.

7. SEX:
Tick appropriate box.

8. PLACE OF BIRTH:
State town and country of birth.

9. NATIONALITY:
State name of country of citizenship.

10. PERMANENT ADDRESS:
State permanent postal address and country.
Enter telephone area code as well as number.

11. PERMANENT ADDRESS:
If different from permanent address, state full current postal address including telephone number and area code. If the same enter 'SAME'.

12. APPLICATION
Tick appropriate box.

13. REFERENCE NUMBER
State reference number allocated to you by the licensing authority. Initial applicants enter "NONE".

14. TYPE OF LICENCE DESIRED:
State type of licence applied for from the following list
ATPL - Airline Transport Pilot Licence
MPL - Multi-crew Pilot Licence
CPL/IR - Commercial Pilot Licence / instrument rating
CPL - Commercial Pilot Licence
PPL/IR - Private Pilot Licence / instrument rating
PPL - Private Pilot Licence
SPL - Sailplane Pilot Licence
BPL - Balloon Pilot Licence
LAPL - Light Aircraft Pilot Licence (aeroplane/helicopter/both)
Other - Please specify

15. OCCUPATION:
Indicate your principal employment.

16. EMPLOYER:
If principal occupation is pilot, then state employer's name or if self-employed state "self".

17. LAST APPLICATION FOR A MEDICAL CERTIFICATE:
State date (day, month, year) and place (town, country), initial applicants state "NONE".

18. LICENCE(S) HELD:
State type of licences held as in box 14. Enter licence number and State of issue for each licence. If no licences are held, state "NONE".

19. ANY LIMITATIONS ON THE LICENCE / MEDICAL CERTIFICATE:
Tick appropriate box and give details of any limitations on your licences / medical certificates, e.g. vision, colour vision, safety pilot, etc.

20. MEDICAL CERTIFICATE DENIAL, SUSPENSION OR REVOCATION:
Tick "YES" box if you have ever had a medical certificate denied, suspended or revoked even if only temporary. If "YES", state date (DD/MM/YYYY) and country where it occurred.

21. FLIGHT TIME TOTAL:
State total number of hours flown.

22. FLIGHT TIME SINCE LAST MEDICAL:
State number of hours flown since your last medical examination.

23. AIRCRAFT CLASS/TYPE(S) PRESENTLY FLOWN:
State name of principal aircraft flown, e.g. Boeing 737, Cessna 150, etc.

24. AIRCRAFT ACCIDENT / INCIDENT
If "YES" box ticked, state date (DD/MM/YYYY) and country of accident/incident.

25. TYPE OF FLYING INTENDED:
State whether airline, charter, agriculture, pleasure, etc. If you conduct single-pilot commercial operations, state also whether you carry passengers against remuneration or not.

26. PRESENT FLYING ACTIVITY:
Tick appropriate box to indicate whether you fly as the sole pilot or not.

27. ALCOHOL
State weekly alcohol consumption e.g. 2 litres beer.

28. DO YOU CURRENTLY USE ANY MEDICATION:
If "YES", give full details - name, how much you take and when, etc. Include any nonprescription medication.

29. DO YOU SMOKE TOBACCO:
Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (e.g. 2 cigars daily; pipe - 1 oz. weekly)

GENERAL AND MEDICAL HISTORY:
All items under this heading from number 101 to 179 inclusive must have the answer "YES" or "NO" ticked. You MUST tick "YES" if you have ever had the condition in your life and describe the condition and approximate date in item 30 Remarks box. All questions asked are medically important even though this may not be readily apparent. Items numbered 170 to 179 relate to immediate family history whereas items 150 to 151 must be answered by female applicants only.

If information has been reported on a previous application form and there has been no change in your condition, you may state "Previously reported, no change since". However, you must still tick "YES" to the condition. Do not report occasional common illnesses such as colds.

31. DECLARATION AND CONSENT TO OBTAINING AND RELEASING INFORMATION:
Do not sign or date these declarations until indicated to do so by the AME who will act as witness and sign accordingly.

To the first page