CIVIL AVIATION MEDICAL EXAMINATION REPORT

PART A

Has the applicants mailing address changed since their last medical? ◯ Yes ◯ No

Type of medical category desired	Aviation medical category held	Permit or Licence number 5802-
Given Names	Family Name	Former Surname
Home Address (Number, street, apartment)		
City	Province	Country / Postal Code

Is the home address the same as the mailing address? ◯ Yes ◯ No (if no, provide details)

Mailing Address (Number, street, apartment)			
City	Province	Country	Postal Code

Telephone number (999-999-9999)	Business telephone (999-999-9999)	Cell number (999-999-9999)	E-mail
Date of Birth (yyyy-mm-dd)	Sex ◯ Male ◯ Female	Citizenship	Language of correspondence ◯ English ◯ French
Employer	Education		

Has the applicant undergone a practical flight test to assess medical fitness to fly? Example: Cockpit assessment due to hearing loss.

◯ No ◯ Yes (if yes, provide details)

Aircraft/vehicle accident since last exam? ◯ Yes ◯ No

Pilot flying time last 12 months	Pilot total flying time

Refusal of issue or renewal of medical certificate? ◯ Yes ◯ No

Has the applicant consulted a physician or other health care provider since their last aviation medical? ◯ No ◯ Yes (if yes, provide details)

Is the applicant in receipt of a pension or other compensation for injury? ◯ No ◯ Yes (if yes, please list all associated medical conditions)

Entered in CAMIS _____

Name	Permit or Licence number	Date of Birth (yyyy-mm-dd)	Date of examination (yyyy-mm-dd)
	5802-		

PART B (To be completed by examiner)

REVIEW OF SYSTEMS

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

1. Head injury, dizziness, loss of consciousness	◯ Yes	◯ No	10. Cardiovascular disorders, hypertension, coronary artery disease, arrhythmia	◯ Yes	◯ No
2. Neurological problems, epilepsy, seizures	◯ Yes	◯ No	11. Musculo - skeletal disorders	◯ Yes	◯ No
3. Ear disease or deafness	◯ Yes	◯ No	12. Allergies	◯ Yes	◯ No
4. Gastrointestinal disorders	◯ Yes	◯ No	13. Menstrual Issues	◯ Yes	◯ No
5. Genito-urinary disorders	◯ Yes	◯ No	14. Vision or eye problems including refractive surgery, cataract surgery, orthokeratology, or intraocular lens implants	◯ Yes	◯ No
6. Alcohol or substance abuse, impaired driving events	◯ Yes	◯ No			
7. Frequent or severe headaches, migraines	◯ Yes	◯ No	15. Diabetes	◯ Yes	◯ No
8. Psychiatric, anxiety, depression, ADHD	◯ Yes	◯ No	16. Cancer	◯ Yes	◯ No
9. Pulmonary disorders including asthma, COPD, OSA	◯ Yes	◯ No	17. Any other medical conditions	◯ Yes	◯ No

Does the applicant have a significant family history of ischemic heart disease (first degree relative with an event before age 55 (if male) or 60 (if female) ?

◯ Yes ◯ No

Please Elaborate on all positive responses above; List relevant family history, past surgical history, and serious illnesses (additional space is available on page 3).

In the past twelve months has the applicant:

1. Used ANY medication to treat a medical condition? (This includes prescription, non-prescription, over-the-counter, herbal medications, cannabis, or cannabis-derived products. *Examples: acetaminophen for backpain, cannabis for anxiety, cannabidiol (CBD) for chronic pain*) ◯ Yes ◯ No

(If yes, please list medication name, dose, and route of administration, frequency, and reason for use)

2. Used tobacco or any product containing nicotine? This includes cigarettes, vaping devices, gum, hookah, cigars, or nicotine patches? ◯ Yes ◯ No

(If yes, please list Product name or type, dose, route of administration, and frequency)

3. Used alcohol? (If yes, average units per week): _____ ◯ Yes ◯ No

4. Used Cannabis or cannabis derived product for non-medical purposes? ◯ Yes ◯ No

5. Used any other drug or substance (excluding cannabis and alcohol), for recreational or non-medical purposes? ◯ Yes ◯ No

(If yes, please list)

Additional Comments

Canada