

# APPLICATION FORM FOR A MEDICAL CERTIFICATE - Class 1, Class 2 & LAPL



## Civil Aviation Directorate

Transport Malta – Civil Aviation Directorate Pantar Road, Lija, LJA 2021, Malta. Tel:+356 2555 5000 [ams.tm@transport.gov.mt](mailto:ams.tm@transport.gov.mt) [www.transport.gov.mt](http://www.transport.gov.mt)

MEDICAL IN CONFIDENCE

Complete this page fully and in **BLOCK CAPITALS** – Refer to instructions for completion

(1) State of licence issue:		(2) Medical certificate applied for: Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> LAPL <input type="checkbox"/>	
(3) Surname:		(4) Previous surname(s):	
(5) Forename(s):		(6) Date of birth (dd/mm/yyyy):	
(8) Place and country of birth:		(7) Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	
(10) Permanent address:  Country: Telephone No.: Mobile No.: e-mail:		(9) Nationality:	
		(11) Postal address (if different):  Country: Telephone No.:	
		(12) Application Initial <input type="checkbox"/> Revalidation/Renewal <input type="checkbox"/>	
		(13) Reference number:	
		(14) Type of licence applied for:	
		(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 licence(s)/medical certificate held No <input type="checkbox"/> Yes <input type="checkbox"/> Details:	
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Country: Details:		(21) Flight time hours total:	
		(22) Flight time hours since last medical:	
		23) Aircraft class/type(s) presently flown:	
(24) Any aviation accident or reported incident since last medical examination? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Place: Details:		(25) Type of flying intended:	
		(26) Present flying activity: Single pilot <input type="checkbox"/> Multi pilot <input type="checkbox"/>	
(27) Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, amount		(28) Do you currently use any medication? No <input type="checkbox"/> Yes <input type="checkbox"/> State drug, dose, date started and why:	
(29) Do you smoke tobacco? <input type="checkbox"/> No, never <input type="checkbox"/> No, date stopped: <input type="checkbox"/> Yes, state type and amount:			

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

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

(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 the 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 sorted 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).

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

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### Data Protection Notice

All data collected in this form is processed in accordance with the Privacy Laws that include General Data Protection Regulation (EU) 2016/679 and Chapter 586 of the Laws of Malta (Data Protection Act). The data provided may be exchanged with other Public Authorities and/or Government Departments as required and permitted by Maltese Law. Transport Malta of Triq Pantar, Lija, Malta LJA2021 is the data controller for the purpose of the privacy laws. The Privacy Notice attached with this application sets out the way in which personal information/data is collected and processed by Transport Malta, as well as the steps that are taken to protect such information.

### Data Protection Privacy Notice

Transport Malta of Triq Pantar, Lija, Malta LJA2021 is the Data Controller for the purpose of the Data Protection Act CAP. 586 and General Data Protection Regulation (EU) 2016/679 (GDPR). This Privacy Notice sets out the way in which we collect and process your Personal Information, as well as the steps we take to protect such information.

#### 1. The information we collect and how we use it

- 1.1. From this application form Transport Malta collects different types of information which information is that required by Law and is used explicitly for your particular application. It is to be noted that if the required information is not provided the said application cannot be processed.
- 1.2. The primary purpose for collecting information is mainly to process the application for the service being applied for, however, your personal information may also be used for related purposes that amongst other include: sending notifications, renewal of licence/certificate after expiry period, and for the provision of information with regards to any legislative amendments which may affect the services offered to you.

#### 2. To whom we disclose information

- 2.1. This information will be solely used for the reasons detailed above. However there may be cases where personal information is shared with the following third parties for reasons listed below:
  - Any third party offering assistance in providing the required service;
  - Any law enforcement body who may have any reasonable requirement to access your personal information;
  - Third party entities responsible for the data processing contracted by Transport Malta.

#### 3. Data Subject Rights

- 3.1. With respect to your privacy rights, Transport Malta is obliged to provide you with reasonable access to the Personal Data that you have provided to us. Your other principal rights under data protection law are:
  - a. the right for information;
  - b. the right to access;
  - c. the right to rectification;
  - d. the right to erasure;
  - e. the right to restrict processing;
  - f. the right to object to processing;
  - g. the right to data portability;
  - h. the right to complain to a supervisory authority; and
  - i. the right to withdraw consent.
- 3.2. If you wish to access or amend any Personal Data we hold about you, or to request that we delete any information about you, you may contact us by sending a request to [dataprotection.tm@transport.gov.mt](mailto:dataprotection.tm@transport.gov.mt). We will acknowledge your request within seventy-two (72) hours and will do our utmost to handle it promptly. We will respond to these requests within a month, with a possibility to extend this period for particularly complex requests in accordance with Applicable Law.
- 3.3. At any time, you may object to the processing of your Personal Data, on legitimate grounds, except if otherwise permitted by applicable law.
- 3.4. In accordance with Applicable Law, we reserve the right to withhold personal data if disclosing it would adversely affect the rights and freedoms of others. Moreover, we reserve the right to charge a fee for complying with such requests if they are deemed manifestly unfounded or excessive.

#### 4. Retention period

- 4.1. Personal data will be retained for not more than 3 months from date of application should the application not be submitted complete or is rejected.
- 4.2. Once the service related to your application is provided, we will retain your information for as long as needed to provide you with our service, or to comply with our legal obligations, resolve disputes and enforce our agreements.

#### 5. Security

- 5.1. We take appropriate security measures to protect against loss, misuse and unauthorized access, alteration, disclosure, or destruction of your information. Additionally, steps will also be taken to ensure the ongoing confidentiality, integrity, availability, and resilience of systems and services processing personal information, and will restore the availability and access to information in a timely manner in the event of a physical or technical incident. All information gathered is kept confidential and is used solely for the purpose indicated herein.
- 5.2. If we learn of a security systems breach, we will inform you of the occurrence of the breach in accordance with applicable law.

#### 6. Governing Law

All data collected in this form is processed in accordance with the Privacy Laws that include General Data Protection Regulation (EU) 2016/679 and Chapter 586 of the Laws of Malta (Data Protection Act).

#### 7. Data Protection Officer

- 7.1. Transport Malta has a Data Protection Officer (“DPO”) who is responsible for matters relating to privacy and data protection. The DPO can be reached at the above address or by email: [dataprotection.tm@transport.gov.mt](mailto:dataprotection.tm@transport.gov.mt)

#### 8. Contacting us

- 8.1. Please address any questions, comments and requests regarding the application process to [civil.aviation@transport.gov.mt](mailto:civil.aviation@transport.gov.mt)

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MEDICAL IN CONFIDENCE

**All areas require completion**

(201) Examination category Initial <input type="checkbox"/> Revalidation <input type="checkbox"/> Renewal <input type="checkbox"/> Referral <input type="checkbox"/>	(202) Height (cm)	(203) Weight (kg)	(204) Colour eye	(205) Colour hair	(206) Blood pressure-seated (mmHg)		(207) Pulse - resting		
					Systolic	Diastolic	Rate (bpm)	Rhythm: regular <input type="checkbox"/> irregular <input type="checkbox"/>	
<b>Clinical exam: Check each item</b>			Normal	Abnormal				Normal	Abnormal
(208) Head, face, neck, scalp					(218) Abdomen, hernia, liver, spleen				
(209) Mouth, throat, teeth					(219) Anus, rectum				
(210) Nose, sinuses					(220) Genito-urinary system				
(211) Ears, drums, eardrum motility					(221) Endocrine system				
(212) Eyes - orbit & adnexa; visual fields					(222) Upper & lower limbs, joints				
(213) Eyes - pupils and optic fundi					(223) Spine, other musculoskeletal				
(214) Eyes - ocular motility; nystagmus					(224) Neurologic - reflexes, etc.				
(215) Lungs, chest, breasts					(225) Psychiatric				
(216) Heart					(226) Skin, identifying marks and lymphatics				
(217) Vascular system					(227) General systemic				
(228) <b>Notes:</b> Describe every abnormal finding. Enter applicable item number before each comment.									

**Visual acuity**

(229) *Distant vision*

	Uncorrected	Corr. to	Spectacles	Contact lenses
Right eye				
Left eye				
Both eyes				

(230) *Intermediate vision*

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(231) *Near vision*

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(232) **Spectacles**

Yes  No

Type: \_\_\_\_\_

<b>Refraction</b>	Sph	Cyl	Axis	Add
Right eye				
Left eye				

(233) **Contact lenses**

Yes  No

Type: \_\_\_\_\_

(233) **Colour Vision**

Normal  Abnormal

Colour vision testing method/s:  
Results: \_\_\_\_\_

(234) **Hearing**

(when 239/241 not performed)

Right ear

Left ear

Conversational voice test (2m) with back turned to examiner	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Audiometry				
Hz	500	1000	2000	3000
Right				
Left				

(249) **AME declaration:**

I hereby certify that I/my AME group have personally examined the applicant named on this aero-medical examination report and that this report with any attachment embodies my findings completely and correctly.

(250) Place and date:	AME name and address:	AME certificate No.
AME signature:	E-mail: Telephone No.: Telefax No.:	

(236) **Pulmonary function**

FEV <sub>1</sub> /FVC _____%	(237) <b>Haemoglobin</b>
_____ (unit)	
Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

(235) **Urinalysis** Normal  Abnormal

Glucose	Protein	Blood	Other

**Accompanying reports**

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) **AME recommendation:**

Name of applicant \_\_\_\_\_ Date of birth: \_\_\_\_\_ Reference number: \_\_\_\_\_

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Fit for class: -----

Medical certificate issued by undersigned (copy attached) for class: -----

Unfit for class: -----

Deferred for further evaluation. If yes, why and to whom?

(248) **Comments, limitations**