Trafikstyrelsen
Danish Civil Aviation and Railway Authority

APPLICATION FORM FOR A MEDICAL REPORT CC

Reference number:

Complete this page fully and in block capitals - Refer to instructions for completion.

MEDICAL IN CONFIDENCE

(1) State of license issue:

(2) Medical report applied for: CC ☐

(3) Surname:

(4) Previous surname(s):

(12) Application: Initial ☐ Revalidation/Renewal ☐

(5) Forename(s):

(6) Date of Birth All dates = (ddmmyyyy):

(7) Sex: ☐ Male ☐ Female

(13) Reference number:

(8) Place and country of birth:

(9) Nationality:

(14) Type of license applied for:

(10) Permanent address:

Country:

Telephone No:

Mobile 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 type:

State of issue:

(19) Any Limitations on License(s)/Medical report ☐ No ☐ Yes

Details

(20) Have you ever had an CC medical report denied, suspended or revoked by any licensing authority?

☐ No ☐ Yes 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 ☐ Yes Date: Place:

Details:

(25) Type of flying intended:

(26) Present flying activity:

Single pilot ☐ Multi pilot ☐

(27) Do you drink alcohol?

☐ No ☐ Yes, amount

(28) Do you currently use any medication?

☐ No ☐ Yes State drug, dose, date started and why:

(29) Do you smoke tobacco?

☐ No, never ☐ 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 (X) and If **yes**, give details in remarks section (30)*

	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	☐	☐
			114 Frequent or severe headaches	☐	☐	125 Sexually transmitted disease	☐	☐	172 High cholesterol level	☐	☐
103 Spectacle/contact lenses prescriptions change since last medical exam.	☐	☐	115 Dizziness or fainting spells	☐	☐	126 Sleep disorder/apnoea syndrome	☐	☐	173 Epilepsy	☐	☐
			116 Unconsciousness for any reason	☐	☐	127 Musculoskeletal illness/impairment	☐	☐	174 Mental illness or suicide	☐	☐
104 Hay fever, other allergy	☐	☐	117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.	☐	☐	128 Any other illness or injury	☐	☐	175 Diabetes	☐	☐
105 Asthma, lung disease	☐	☐				129 Admission to hospital	☐	☐	176 Tuberculosis	☐	☐
106 Heart or vascular trouble	☐	☐	118 Psychological/psychiatric trouble of any sort	☐	☐	130 Visit to medical practitioner since last medical examination	☐	☐	177 Allergy/asthma/eczema	☐	☐
107 High or low blood pressure	☐	☐							178 Inherited disorders	☐	☐
108 Kidney stone or blood in urine	☐	☐	119 Alcohol/drug/substance abuse	☐	☐	131 Refusal of life insurance	☐	☐	179 Glaucoma	☐	☐
109 Diabetes, hormone disorder	☐	☐	120 Attempted suicide or self-harm	☐	☐	132 Refusal of flying licence	☐	☐	**Females only:**		
110 Stomach, liver or intestinal trouble	☐	☐	121 Motion sickness requiring medication	☐	☐	133 Medical rejection from or for military service	☐	☐	150 Gynaecological, menstrual problems	☐	☐
111 Deafness, ear disorder	☐	☐	122 Anaemia/sickle cell trait/other blood disorders	☐	☐	134 Award of pension or compensation for injury or illness	☐	☐	151 Are you pregnant?	☐	☐

(30) **Remarks:** If previously reported and no change since, so state.

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(31) **Declaration (Samtykkeerklæring) concerning medical information:**

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 report or may withdraw any medical report 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 the 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.

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