Which airline are you training with or working for?________________________________

APPLICATION FOR CABIN CREW INITIAL MEDICAL ATTESTATION

Civil Aviation Directorate
Transport Malta – Civil Aviation Directorate, Pantar Road, Lija, LJA 2021, Malta.Tel:+356 2555 2365 Fax:+356 2123 9278 info.tm@transport.gov.mt www.transport.gov.mt

MEDICAL IN CONFIDENCE

Complete this page fully using a black ball point pen and in BLOCK CAPITALS

(1) Surname:	(2) Previous surname(s):	(3) Title:
(4) Forenames:	(5) Date of birth:	(6) Sex: Male ☐ Female ☐
(7) Place and country of birth:	(8) Nationality:	

(9) Address: Postcode: Country: Telephone No: Mobile No:	(10) GP Name: Address: Telephone No:						
(11) Alcohol – state average weekly intake units:	(12) Do you currently use any medication? Yes ☐ No ☐ If YES, State name of medication, dose, date started and why.	M	M	Y	Y	Y	Y
(13) Do you smoke tobacco? Yes ☐ No ☐ If no, date stopped: Never ☐							

General and medical history: Do you have , or have you ever had, any of the following? YES (Y) or NO (N) must be ticked after each question. If you have ticked YES give details below.

	Y	N		Y	N		Y	N		Y	N
Problem with distant or close vision			Stomach, liver or intestinal trouble			Alcohol, drug or substance abuse			**Females Only**		
Glasses or contact lenses worn			Ear disorder			Attempted Suicide			Gynecological or menstrual problems		
Eye disease or surgery			Hearing problem			Anemia, sickle cell disease or other blood disorder			Are you pregnant?		
Hay fever			Nose, throat or sinus disorder			Malaria or other tropical disease					
Allergy			Speech difficulties			A positive HIV test			**Family history of :**		
Asthma or lung problem			Headaches or migraine			Infectious disease			Heart disease High blood pressure		
Any form of heart or vascular disease or stroke			Epilepsy or seizure			Admission to hospital			High cholesterol level Epilepsy		
High blood pressure			Dizziness, episode of fainting or unconsciousness for any reason			Illness or injury not otherwise specified			Mental illness Diabetes		
Kidney stone or blood in urine			Neurological disorders			Skin disorder			Tuberculosis Allergy, asthma or eczema		
Diabetes or hormone disorder			Psychiatric or psychological trouble of any sort			Disorder affecting strength or movement or arthritis			Inherited disorder Glaucoma		

Details:

Declaration : I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement.

Signature: ………………………………………………………………………………… Date: ……………………………..........................

EASA / UK CAA/ FAA / GCAA MEDICAL CONSENT FORM

Tick
☐ I hereby give my informed consent to undergo an EASA/ FAA /UKCAA /GCAA Class I, II, III, ATCO, LAPL or Cabin Crew medical examination or assessment (including substance abuse testing if required).

☐ I hereby give my explicit consent for FlyingMedicine Ltd to process my personal data (GDPR articles 6.1a-f and 9.2) and understand FlyingMedicine Ltd has a legal obligation under data protection laws (GDPR) to share my personal data with any relevant regulatory bodies e.g., UK Civil Aviation Authority, European Aviation Safety Agency (EASA), Federal Aviation Administration (FAA)/ General Civil Aviation Authority (GCAA).

Further information can be found via our privacy policy at www.flyingmedicine.uk
☐ I do not require a chaperone for the clinical examination
☐ I require a chaperone for the clinical examination

☐ I confirm I give my permission for Flying Medicine ltd to send my reports electronically and or in hard copy to the relevant bodies as directed.

☐ I confirm that I will FULLY disclose ALL my past and current medical information on the relevant forms and to the Aeromedical Examiner (AME) and understand that failure to be honest, full and complete with my statements can lead the authorities to seek legal redress and possible custodial sentences.

☐ I agree that Flying Medicine ltd will not be held liable for ANY costs incurred should relevant medical standards are not met on the day or there is a delay in licensing.

☐ I further agree that Flying Medicine ltd and the examining AME will not be held liable for the costs of any further, additional investigations, tests, specialist consultations and or downtime from work that may be deemed necessary to attain the medical standards and that I will therefore remain solely liable for ALL additional costs incurred.

☐ I am aware that there is an appeals process via the relevant Civil Aviation Authority.

☐ I understand I am liable for the full payment for the entire medical process including all additional tests (ECGs/ Audiograms/ Blood checks) and reports reviews in order for issuance and maintenance
of the medical certificate- noting that review of reports and their processing in chargeable in addition to the
medical assessment.

☐ I confirm I have carefully read the above statements and sought clarification where necessary

Please follow us on Instagram - flyingmedicine or X = flying_medicine or facebook- flyingmedicine

☐ If you'd like us to follow you on social media advise the platform and your account -

Name: Date of Birth: Signature: Date:

flyingmedicine.uk
Aeromedical Solutions

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				

CAGE Questionnaire		
1. Have you felt the need to **C**ut down on your drinking?	Yes (1)	No (0)
2. Do you feel **A**nnoyed by people complaining about your drinking?		
3. Do you ever feel **G**uilty about your drinking?		
4. Do you ever drink an **E**ye-opener in the morning to relive the shakes?		
Score		

Name: Signature: Date: