

# Medical Certificate Application form



I apply to the Director of Civil Aviation for a medical certificate, and hereby request a Medical Examiner to examine me for that purpose. I understand that I must pay the required Medical Certificate Application Fee as required by the Civil Aviation Fees and Charges **before** I attend an appointment with a Medical Examiner.

## PAYMENT DETAILS

CAA Medical Examiner to complete

Receipt Number (attach confirmation):

Date Payment Made:

CAA Medical Examiner to sight and verify confirmation

For more information

[www.mcaa.gov.mn](http://www.mcaa.gov.mn)

## YOUR INFORMATION (to be completed by applicant)

Title: Mr  Mrs  Miss  Ms  \_\_\_\_\_

First Names:

Surname: (If changed recently, give previous surname in brackets & attach evidence)

Known As:

CAA Client ID:

Age:

Date of Birth: (DD/MM/YYYY)

Gender: (please tick)

M  F

Address for Service:

CAR, requires applicants to provide an address for service and to promptly notify the Director of any changes.

City/Town:

Postcode:

Postal Address: (If different from Address for Service)

City/Town:

State:

Country:

Postcode:

Phone No: (Business)

Phone No: (Private)

Mobile:

Email:

Certificate applied for:

Class 1 & 2  Class 2  Class 2 – No IFR  Class 3

Aviation document currently held:

ATPL  CPL  Private  RPL  ATC  None Yet

**Other or previous licences:** Have you ever had a civil aviation licence or medical certificate issued before, either in Mongolia or from another authority? (Please give the year, country and licence type/number)

Employer:

Aero Club / Training Facility:

Occupation:

Aircraft types flown recently:

Hours you have flown:

Total:

Last 6 months:

General Practitioner contact details: (must be supplied)

**MEDICAL HISTORY** Have you ever experienced any of the following: (please tick the correct answer)

		Yes	No
1.1	Eye or vision trouble	<input type="radio"/>	<input type="radio"/>
1.2	Needed new glasses or contact lenses since last CAA medical examination	<input type="radio"/>	<input type="radio"/>
1.3	Eye or corneal surgery	<input type="radio"/>	<input type="radio"/>
1.4	Hay fever	<input type="radio"/>	<input type="radio"/>
1.5	Middle ear infection	<input type="radio"/>	<input type="radio"/>
1.6	Sinusitis	<input type="radio"/>	<input type="radio"/>
1.7	Hearing trouble	<input type="radio"/>	<input type="radio"/>
1.8	Problems with balance	<input type="radio"/>	<input type="radio"/>
1.9	Any other ears, nose & throat problems or surgery	<input type="radio"/>	<input type="radio"/>
1.10	Asthma or wheezing	<input type="radio"/>	<input type="radio"/>
1.11	Chronic cough	<input type="radio"/>	<input type="radio"/>
1.12	Any other lung problems	<input type="radio"/>	<input type="radio"/>
1.13	Any shortness of breath	<input type="radio"/>	<input type="radio"/>
1.14	Pulmonary embolism or deep vein thrombosis	<input type="radio"/>	<input type="radio"/>
1.15	Coughed or vomited blood	<input type="radio"/>	<input type="radio"/>
1.16	Any severe allergy	<input type="radio"/>	<input type="radio"/>
1.17	Heart problem	<input type="radio"/>	<input type="radio"/>
1.18	Vascular problem	<input type="radio"/>	<input type="radio"/>
1.19	Suffered any chest pain	<input type="radio"/>	<input type="radio"/>
1.20	Rheumatic fever	<input type="radio"/>	<input type="radio"/>
1.21	High or low blood pressure	<input type="radio"/>	<input type="radio"/>
1.22	Severe abdominal pain	<input type="radio"/>	<input type="radio"/>
1.23	Hernia	<input type="radio"/>	<input type="radio"/>
1.24	Oesophagus, stomach, liver, gall bladder or intestinal trouble	<input type="radio"/>	<input type="radio"/>
1.25	Diagnosed or treated for cancer, tumour, growth or malignancy (including skin cancer)	<input type="radio"/>	<input type="radio"/>
1.26	Anaemia or blood disease	<input type="radio"/>	<input type="radio"/>
1.27	Headaches/migraines which have interfered in any way with daily living	<input type="radio"/>	<input type="radio"/>
1.28	Headaches/migraines requiring medication	<input type="radio"/>	<input type="radio"/>
1.29	Dizziness or fainting spell	<input type="radio"/>	<input type="radio"/>
1.30	Unconsciousness for any reason	<input type="radio"/>	<input type="radio"/>
1.31	Head injury	<input type="radio"/>	<input type="radio"/>
1.32	Seizures/fits	<input type="radio"/>	<input type="radio"/>
1.33	Stroke	<input type="radio"/>	<input type="radio"/>
1.34	Paralysis	<input type="radio"/>	<input type="radio"/>
1.35	Any other neurological disorder	<input type="radio"/>	<input type="radio"/>
1.36	Diagnosed depression	<input type="radio"/>	<input type="radio"/>

		Yes	No
1.37	Anxiety disorder/panic disorder	<input type="radio"/>	<input type="radio"/>
1.38	Learning difficulty	<input type="radio"/>	<input type="radio"/>
1.39	Attention deficit or hyperactivity disorder	<input type="radio"/>	<input type="radio"/>
1.40	Post traumatic stress disorder	<input type="radio"/>	<input type="radio"/>
1.41	Suicide attempt	<input type="radio"/>	<input type="radio"/>
1.42	Any other mental illness	<input type="radio"/>	<input type="radio"/>
1.43	Substance dependence or substance abuse	<input type="radio"/>	<input type="radio"/>
1.44	Use of legal or illegal recreational drugs or substances	<input type="radio"/>	<input type="radio"/>
1.45	Alcohol dependence or abuse	<input type="radio"/>	<input type="radio"/>
1.46	Muscle, bone or joint injury	<input type="radio"/>	<input type="radio"/>
1.47	Back pain, injury or 'back trouble'	<input type="radio"/>	<input type="radio"/>
1.48	Swollen or painful joints	<input type="radio"/>	<input type="radio"/>
1.49	Suffered any pain severe enough to be disabling	<input type="radio"/>	<input type="radio"/>
1.50	Passed blood with or in urine or faeces	<input type="radio"/>	<input type="radio"/>
1.51	Kidney, bladder or prostatic disease	<input type="radio"/>	<input type="radio"/>
1.52	Easy fatigue-ability or sleep in the day	<input type="radio"/>	<input type="radio"/>
1.53	Investigations for abnormal glucose tolerance, high blood sugar, or diabetes	<input type="radio"/>	<input type="radio"/>
1.54	Medical Certificate for absence of 7 or more days from work or school	<input type="radio"/>	<input type="radio"/>
1.55	Rejection or premium loading for life or health insurance	<input type="radio"/>	<input type="radio"/>
1.56	Rejection or retirement from employment on medical grounds	<input type="radio"/>	<input type="radio"/>
1.57	Admission to hospital, psychiatric or in patient facility	<input type="radio"/>	<input type="radio"/>
1.58	Taken any type of medicine or alternative medicine for more than 2 weeks	<input type="radio"/>	<input type="radio"/>
1.59	Had a positive laboratory test for HIV infection	<input type="radio"/>	<input type="radio"/>
1.60	Investigation for any disorder	<input type="radio"/>	<input type="radio"/>
1.61	Any major medical or surgical procedure	<input type="radio"/>	<input type="radio"/>
1.62	Day surgery	<input type="radio"/>	<input type="radio"/>
1.63	Any other illness, disability, debility, infirmity, treatment or surgery	<input type="radio"/>	<input type="radio"/>
<b>FEMALES ONLY</b>			
1.64	Any troubling menstrual problems	<input type="radio"/>	<input type="radio"/>
1.65	Other gynaecological problem	<input type="radio"/>	<input type="radio"/>
1.66	Any obstetric problem	<input type="radio"/>	<input type="radio"/>
1.67	Breast lump or other breast problem	<input type="radio"/>	<input type="radio"/>
1.68	Pregnancy – Are you pregnant?	<input type="radio"/>	<input type="radio"/>

- |  |                       |                       |
|--|-----------------------|-----------------------|
|  | Yes                   | No                    |
| 2. Have you ever had any medical certificate denied, suspended, or revoked within or outside of Mongolia?  | <input type="radio"/> | <input type="radio"/> |
| 3. Have you ever been convicted of an alcohol or drug-related offence, including a drink-driving offence, or is any action pending for such an offence?                      | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever received any Notice under the Civil Aviation Act (suspension, restriction, endorsements, etc) during the period of the current or last medical certificate? | <input type="radio"/> | <input type="radio"/> |

**FAMILY HISTORY**

5. Have any members of your family had vascular disease, hypertension, diabetes, heart disease, psychiatric disease or neurological disease? (If Yes, please mention below the name of the disease and the age when discovered)  Yes  No

<i>Mother</i>	<i>Father</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<i>Siblings</i>	<i>Grandparents</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<i>Other</i>	
<input style="width: 100%;" type="text"/>	

**SMOKING**

6. Have you ever smoked? Yes  No

<i>If yes – In total, how many years have you smoked for?</i>	<i>Average quantity smoked (Packs/week)</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

- Are you still smoking or have you smoked within the last 12 months? Yes  No

**ALCOHOL (LAST 12 MONTHS)**

7. How often do you have a drink containing alcohol?  
 Never  Monthly or less  2-4 times a month  2-3 times a week  4 or more times a week
8. How many drinks containing alcohol do you have on a typical day when you are drinking?  
 1 or 2  3 or 4  5 or 6  7 or 9  10 or more  Total number of units per week
9. How often do you have six or more drinks on one occasion?  
 Never  Less than monthly  Monthly  Weekly  Daily or almost daily

10. Have you **VISITED** a health professional within the last 3 years? (If yes, explain below) Yes  No

<i>Date visited:</i>	<i>GP/Specialist:</i>	<i>Reason for visit:</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

11. Have you taken any **MEDICATION** in the past 3 years for two weeks or more? (If yes, explain below) Yes  No

<i>Name:</i>	<i>Dosage:</i>	<i>Purpose:</i>	<i>Date started:</i>	<i>Date finished:</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

If you have answered 'Yes' to any questions from 1-11, please provide all details of each instance (Please use extra pages or attach documents as required)

<i>Question No:</i>	<i>Details:</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

**CONSENT**

I consent to the disclosure to the Director and/or his delegate, of any medical or health information relating to me which is held by a registered medical practitioner, hospital or other organisation.

I consent to government agencies including the Mongolian Transport Agency and the Ministry of Justice disclosing to the Director information about any convictions I have or current charges against me.

I consent to the Civil Aviation Authority and the Director of Civil Aviation using information about me for any reasonable purpose:

- related to this medical certificate application, and/or
- related to the powers, duties and functions of the Civil Aviation Authority and the Director of Civil Aviation.

I consent to the Civil Aviation Authority and Director disclosing this information to any person who requires such information to carry out any function authorised by law.

I understand that the Civil Aviation Authority and Director may provide relevant medical information to other international jurisdictions in the interests of aviation safety.

**ACKNOWLEDGEMENT**

I acknowledge and understand the following:

That I have obligations under the Civil Aviation Act and CAR, in relation to –

1. the provision of information, for the purpose of obtaining a medical certificate. I understand that failing to comply with these obligations is an offence, and
2. advising a medical examiner or reporting to the Director if I become aware of, or suspect that there is any change in my medical condition or the existence of a previously undetected medical condition that may interfere with the safe exercise of the privileges to which my medical certificate relates, and
3. advising a medical examiner or reporting to the Director if I am charged with any alcohol or drug related offence, and
4. the making or causing to be made of any fraudulent, misleading, or intentionally false statement for the purpose of obtaining a medical certificate constitutes an offence under the Civil Aviation Act, Violation Law, and is subject, in the case of an individual, to a fine equal to 300 unit MNT under Violation Law 14.8(3), and
5. the failure to notify the Director of any change in medical condition or the existence of a previously undetected medical condition constitutes an offence under the Civil Aviation Act and Violation Law, and is subject, in the case of an individual, to a fine equal to 300 unit MNT under Violation Law 14.8(3).

I have read this application form, familiarised myself with it and understand its contents, including the consent and acknowledgment in the above paragraphs. I confirm that all the information that I have entered onto this form is true and accurate in all respects:

Applicant's Signature:

Date:

I have explained this form to the applicant and confirm that he/she has signed it in my presence.

Medical Examiner's Signature:

Date:

Medical Examiner's Name and/or Stamp: