SOUTH AFRICAN CIVIL AVIATION AUTHORITY
South Africa

South African Civil Aviation Authority

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Physical address: Ikhaya Lokundiza, 16 Treur Close, Waterfall Park, Bekker Street, Midrand, Gauteng
Postal address : Private Bag X73, Halfway House 1685

Medical in Confidence

(1) State applied to:

(2) Class of medical certificate applied for: ☐ 1 ☐ 2 ☐ 4 ☐ 3 ☐ Cabin Crew ☐ Others

(3) Surname:

(4) Previous surname(s):

(5) Forename(s):

(6) Date of birth: Id

(7) Sex: ☐ Male ☐ Female

(8) Place and country of birth:

(9) Nationality:

(10) Permanent address:

Telephone No.:
Mobile No.:
E-Mail:

(11) Postal address (if different):

Telephone No.:

(12) Application:
☐ Initial
☐ Renewal/Revalidation

(13) Reference number:

Social Security Number

(14) Type of licence applied for:

(15) Occupation (principal):

(16) Employer:

(17) Last medical examination:
Date:
Place:

(18) Licence(s) held (type): Licence number: State of issue:

(19) Any limitations on licence(s)/medical certificate held:
☐ No ☐ Yes
Details:

(20) Have you ever had medical certificate denied, suspended or revoked by any licensing authority?
☐ No ☐ Yes Date: Country:
Details:

(21) Flight time total:

(22) Flight time since last medical:

(23) Aircraft class/type(s) presently flown:

(24) Any aviation accident or reported incident since the last medical examination?
☐ No ☐ Yes Date: Place:
Details:

(25) Type of flying intended:

(26) Current flying activity: ☐ Single pilot ☐ Multi pilot
Current ATCO activity: ☐ TWR ☐ APP ☐ ACC

(27) Do you drink alcohol? ☐ No ☐ Yes, amount

(28) Do you currently use any medication ☐ No ☐ Yes
State medication, 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). If yes, give details in remarks section (30).

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

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

(31) Declaration by applicant : I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete and correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statement in connection with this application, or if I do not consent to release the support, the supporting medical information, the Authority may refuse to grant me Medical Assessment or may withdraw any Medical Assessment granted, without prejudice to any other legal action applicable pursuant.

Consent to release of medical information: I hereby give my consent that all relevant medical information may be released and submitted to the Medical Assessor of the Licensing Authoritiy. Note: Medical Confidentiality will be respected all times.

Date	Signature of applicant	Signature of AME / medical assessor	Examiner's Name and Address:

SOUTH AFRICAN CIVIL AVIATION AUTHORITY

Section/division **Aviation Medicine**
Telephone number: **011-545-1000**
Physical address **IkhayaLokundiza, 16 Treur Close, WaterfallPark, Bekker Street, Midrand, Gauteng**
Postal address: **Private Bag X73, Halfway House 1685** *Website:* **www.caa.co.za**

Form Number: CA 67-08

AVIATION MENTAL SCREENING QUESTIONNAIRE

1.	**PERSONAL INFORMATION**			
1.1.	Surname			
1.2.	First name(s)			
2.	**SUGGESTED QUESTIONS FOR DEPRESSION**			
2.1.	Do you have, or have you ever had, any of the following? Yes or No must be ticked after each question.		**YES**	**NO**
2.1.1.	During the past three months, have you often been bothered by feeling down, depressed, or hopeless?			
2.1.2.	During the past three months, have you often been bothered by having little interest or pleasure in doing things?			
2.1.3.	During the past three months, have you been bothered by having problems falling asleep, staying asleep, or sleeping too much, that is unrelated to sleep disruption from night flying or trans meridian operations?			
2.1.4.	In the past three months, has there been a marked elevation in your mood lasting for more than one week?			
2.1.5.	Other, please specify in detail:			
3.	***SUGGESTED QUESTIONS FOR ANXIETY/PANIC ATTACK***		**YES**	**NO**
3.1.	In the past three months, have you had an episode of feeling sudden anxiety, fearfulness, or uneasiness?			
3.2.	In the past three months, have you experienced sensations of shortness of breath, palpitations (racing heartbeat) or shaking while at rest without reasonable cause?			
3.3.	In the past year have you needed to seek urgent medical advice because of anxiety?			
4.	**SUGGESTED QUESTIONS CONCERNING ALCOHOL USE:**		**YES**	**NO**
4.1.	Have you ever felt that you should cut down on your drinking?			
4.2.	Have people annoyed you by criticizing your drinking			
4.3.	Have you ever felt guilty about your drinking?			
4.4.	Have you ever needed a drink first thing in the morning?			
4.5.	How many alcoholic drinks would you have in a typical week?			
4.6.	How many alcoholic drinks would you have on a typical day when you are drinking?			
5.	**SUGGESTED QUESTIONS CONCERNING DRUG USE:**		**YES**	**NO**
5.1.	Have you used drugs other than those required for medical reasons?			
5.2.	Which non-prescription (over the counter) drugs have you used? When did you last use this drug(s)?			
6.	Other -pls provide MIRE information			

Aviation Medical Examiner to comment in full on all items marked YES. Please attach additional pages if space is insufficient & Applicants not required to sign this section

NOTICE

SIGNATURE OF AME	**NAME IN BLOCK LETTERS**	**DATE**

ID Number/Passport No.		Date	

SOUTH AFRICAN CIVIL AVIATION AUTHORITY

Department: Aviation Medicine
Telephone number: 0860 267 435 *Email address:* **ClientCare@caa.co.za**
Physical address **Ikhaya Lokundiza, 16 Treur Close, Waterfall Park, Bekker Street, Midrand, Gauteng**
Postal address: **Private Bag X73, Halfway House 1685** *Website:* **www.caa.co.za**

Form Number: CA 67-39

SACAA CLIENT CONSENT FORM

CONSENT AGREEMENT

The Protection of Personal Information Act 4 of 2013 ("POPI Act") requires that personal information pertaining to individuals be processed lawfully and in a reasonable manner that does not infringe on their right to privacy. Your privacy is important to the South African Civil Aviation Authority ("SACAA"), and we are committed to safeguarding and processing your information lawfully. To ensure compliance to the POPI Act please complete the below to grant consent to a third party involved in the aviation medical certification processes, i.e. **Designated Aviation Medical Examiner/s, Aeromedical Committee Specialist/s, Medical Appeal Specialist/s .Department of Transport Board ,Institute of Aviation Medicine (South African Military Health Services)holder, courier services, consultant, family member, insurance ,medical aid employee/employer, and other**

By completing and signing this form, I hereby give consent to: _____

(insert full names here) a third party to provide the following services (tick appropriate boxes below)

Submit my application		Have access to my SACAA information.		Collect my license/document/ approval on my behalf.	

LICENCE HOLDER / APPLICANT DETAILS

Surname:		Initials	
ID/passport No: Copy should be attached to this form			
Details of Application:			
Licence / Approval Number			

I declare that the information provided in the Consent Form is accurate to the best of my knowledge and that I accept the conditions and undertakings requested this process.

SACAA shall secure the integrity and confidentiality of your Personal Information by taking appropriate, reasonable technical and organisational measures to prevent any loss, damage or unauthorised destruction of Personal Information including unlawful access or processing of your Personal Information as provided for in the POPI Act.

I, the undersigned applicant, hereby indemnify the SACAA, from any liability which may arise because of the information, documents, approvals being released to a third party or proxy.

SIGNATURE OF APPLICANT	**NAME IN BLOCK LETTERS**	**DATE**

APPLICANTS REPRESENTATIVE / PROXY

Surname:		**Initials**	
Company Name (if applicable)			