

In accordance with Article 10(2) and Article 119(2) of the Aviation Act ("Official Gazette of the Republic of North Macedonia" No. 14/24, 224/24 and 3/25), and in reference to Article 3 of Multilateral Agreement between the European Community and its Member States, the Republic of Albania, Bosnia and Herzegovina, the Republic of Bulgaria, the Republic of Croatia, the Republic of Macedonia, the Republic of Iceland, the Republic of Montenegro, the Kingdom of Norway, Romania, the Republic of Serbia and the United Nations Interim Administration Mission in Kosovo on the establishment of a European Common Aviation Area ratified with the Act of Ratification of Multilateral Agreement ("Official Gazette of the Republic of Macedonia No. 27/07, 98/09 and "Official Gazette of the Republic of North Macedonia" No. 259/19) the Director General of the Civil Aviation Agency enacted

REGULATION ON AVIATION PERSONNEL MEDICAL FITNESS

Article 1

The present Regulation stipulates the special requirements for aviation personnel medical fitness operating civil aviation, special conditions, manner and procedure for performing aviation medical examinations, for aero-medical assessment and obtaining appropriate certificates.

Article 2

(1) During the implementation of the provisions of this Regulation certain terms have the following meaning:

1. EASA is the European Aviation Safety Agency;
2. The national aviation authority, the competent authority, the competent authority of the Member States shall be interpreted, if applicable, as the Civil Aviation Agency.

(2) The terms "Community", "Community Law", "Community Legislation", "Community Instruments", "EC Treaty", "Community airport", "Official Journal of the European Communities", "Official Journal of the European Union", "Community air carrier" and "Member State(s)" used in EU Regulations from item 3 of this Article are read in accordance with points 2 and 3 of the Annex II of the Multilateral Agreement between the European Community and its Member States, the Republic of Albania, Bosnia and Herzegovina, the Republic of Bulgaria, the Republic of Croatia, the Republic of Macedonia, the Republic of Iceland, the Republic of Montenegro, the Kingdom of

Norway, Romania, the Republic of Serbia and the United Nations Interim Administration Mission in Kosovo on the establishment of a European Common Aviation Area ratified with the Act of Ratification of Multilateral Agreement ("Official Gazette of the Republic of Macedonia No. 27/07, 98/09 and "Official Gazette of the Republic of North Macedonia" No. 259/19).

(3) Other terms during the implementation of this Regulation shall have the meaning established in the Regulation (EU) 2018/1139 of the European Parliament and of the Council of 4 July 2018 on common rules in the field of civil aviation and establishing a European Union Aviation Safety Agency, and amending Regulations (EC) No 2111/2005, (EC) No 1008/2008, (EU) No 996/2010, (EU) No 376/2014 and Directives 2014/30/EU and 2014/53/EU of the European Parliament and of the Council, and repealing Regulations (EC) No 552/2004 and (EC) No 216/2008 of the European Parliament and of the Council and Council Regulation (EEC) No 3922/91 amended by EU Regulation No 2021/1087 (hereinafter: **EU Regulation 2018/1139**), that according Article 2 of Regulation for common basic rules for safety for the activities in the civil aviation is accepted and directly applied, Commission Regulation (EU) No 1178/2011 of 3 November 2011 laying down technical requirements and administrative procedures related to civil aviation aircrew pursuant to Regulation (EC) No 216/2008 of the European Parliament and of the Council amended by EU Regulations No. 290/2012, 70/2014, 245/2014, 2015/445, 2016/539, 2018/1065, 2018/1119, 2018/1974, 2019/27, 2019/430, 2019/1747, 2020/359, 2020/723, 2020/2193, 2021/2227, 2023/203, 2024/1111 and 2024/2076 (hereinafter: **EU Regulation 1178/2011**) and Commission Regulation (EU) 2015/340 of 20 February 2015 laying down technical requirements and administrative procedures relating to air traffic controllers' licences and certificates pursuant to Regulation (EC) No 216/2008 of the European Parliament and of the Council amended by EU Regulations No. 2023/203 and 2023/893 (hereinafter: **EU Regulation 2015/340**) accepted and directly applied and published on the Agency's website.

Article 3

(1) The aviation personnel who is subject to aero-medical assessments according to regulations enacted in accordance with the Aviation Act, is issued with medical certificate.

(2) The aviation personnel referred to in paragraph (1) of this Article, depending on the medical certificates type of them are divided into:

- Class 1, including applicants and holders of a Commercial Pilot Licence (CPL), a Multi-Crew Pilot Licence (MPL), an Airline Transport Pilot Licence (ATPL) and flight engineers;

- Class 2, including applicants and holders of a Private Pilot Licence (PPL), a Sailplane Pilot Licence (SPL), a Balloon Pilot Licence (BPL), pilot on dual wings for free flying, dual instructor for parachute and flight navigators;
- Class 3, including air traffic controllers and students air traffic controllers;
- Class 4, including aviation personnel not covered by the classes in lines 1, 2 and 3 of this paragraph, and subject to aero-medical assessments in accordance with the regulations for the relevant aviation personnel and
- light aircraft pilot licence (LAPL) including applicants for and license holders of a light aircraft pilot licence (LAPL).

(3) By way of derogation from paragraph (1) of this Article, applicants for, or holders of, a cabin crew certificate shall be issued with a cabin crew medical report.

Article 4

The essential requirements for medical fitness of aviation personnel Classes 1, 2 and 3, light aircraft pilot licence (LAPL) and cabin crew, as well as for conducting aero-medical assessments, oversight of medical assessment and obtaining appropriate certificates are laid down EU Regulation 2018/1139.

Article 5

(4) The special medical fitness requirements of aviation personnel of Class 1 and 2, light aircraft pilot licence (LAPL) and cabin crew, as well as the special requirements, manner and procedure for conducting aero-medical assessments, oversight of medical assessment and obtaining appropriate certificates are laid down in EU Regulation 1178/2011.

(5) General medical practitioners (GMP) may conduct aero-medical assessments to aviation personnel in accordance with this Regulation, if obtaining authorization for an aero-medical examiner (AME).

(6) During the implementation of the EU Regulation 1178/2011 and its amendments from paragraph (1) of this Article the Decision No 2012/006/R of the EASA Executive Director containing Acceptable Means of Compliance (AMC) and the Guidance Material regarding the EU Regulation 1178/2011 (Part-MED/AMC/GM and Part-ARA/AMC/GM), including all the amendments regarding those EU Regulations, accepted and directly applied and published on the EASA website.

(7) As an exception to paragraph (1) of this Article, special medical fitness requirements to Class 2 flight navigator, as well as the special requirements, manner and procedure for conducting aero-medical assessments, oversight of medical assessment and obtaining appropriate certificates are laid down in ICAO Annex 1 to the Convention on International Civil Aviation.

Article 6

(1) The special medical fitness requirements for Class 3 aviation personnel capability, as well as the special requirements, manner and procedure for conducting aero-medical assessments, oversight of medical assessment and obtaining appropriate certificates are laid down in EU Regulation 2015/340.

(2) During the implementation of EU Regulation 2015/340 and its amendments from paragraph (1) of this Article the Decision No 2015/010/R of the EASA Executive Director containing Acceptable Means of Compliance (AMC) and the Guidance Material regarding the EU Regulation 1178/2011 (Part - ATCO.MED - AMC/GM and Part - ATCO.AR - AMC / GM), including all the amendments regarding those EU Regulations, accepted and directly applied and published on the EASA website.

Article 7

In reference to point ARA.MED.325 of EU Regulation 1178/2011, on secondary review of aviation personnel medical fitness Class 1, 2 and 3, as well as for light aircraft pilot licence (LAPL), the provisions of point 5 of the Annex shall apply accordingly, being an integral part to this Regulation.

Article 8

The special requirements, for the aviation personnel medical fitness Class 4, as well as the special requirements, manner and procedure for conducting aero-medical assessments, oversight of medical assessment and obtaining appropriate certificates are laid down in the Annex to this Regulation.

Article 9

(1) For obtaining the relevant certificates for conducting aero-medical assessments from Articles 5, 6 and 8 of this Regulation, an application is submitted to the Agency with proof of paid administrative tax, proof of paid tax in accordance with the Agency's Tariff Regulation and evidence of meeting the conditions of this Regulation.

(2) The provisions of the Law on General Administrative Procedure shall be applied subsidiarily to the procedure for issuance or amendment of relevant certificates for conducting aero-medical assessments if not otherwise determined by the EU Regulations 1178/2011 and 2015/340 and by the Annex to this Regulation.

(3) As an exception to paragraph (2) of this Article, during the procedures foreseen with this Regulation, the applicants, may also submit proofs of meeting the conditions on English language.

(4) As an exception to paragraph (2) of this Article, the administrative procedures for issuance or change of relevant certificates for conducting aero-medical assessments are performed in 120 days, from the day on their initiation.

(5) The deadline from paragraph (4) of this Article starts from the day the documentation is completely submitted to the appropriate application, of which the Agency will notify the applicant.

Article 10

The approved aeromedical centres and medical practitioner should harmonize their operating procedures with the requirements of this Regulation within one year from the date of entering into force of this Regulation at the latest.

Article 11

(1) The provisions of EU Regulation 2024/1111 referred to in Article 2 of this Regulation, amending EU Regulation 1178/2011 shall start to apply from 1 September 2025.

(2) The provisions from point (7) of Annex I, Annex II, points (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (22) and (23) of Annex III, points (2), (3), (4), (5), (6), (7), (8) and (9) of Annex IV and Annex VII of EU Regulation 2024/2076 from Article 2 of this Regulation, amended by EU Regulation 1178/2011, shall apply from 1 September 2025.

(3) The provisions of EU Regulation 2023/203 from Article 2 of this Regulation, amending EU Regulations 1178/2011 and 2015/340 shall apply from 1 January 2027.

(4) The provisions of EU Regulation 2023/893 from Article 5 of this Regulation, amending Regulation 2015/340 shall apply from 1 January 2026.

Article 12

On the day of entering into force of this Regulation the Regulation on requirements, method and procedure for establishment of medical fitness of aviation personnel, period of validity of medical certificates and special requirements to be met by aeromedical centres, authorized medical examiner, general medical practitioners or occupational health medical practitioners to carry out medical examinations of the aviation personnel ("Official Gazette of the Republic of North Macedonia" No. 221/23) shall cease to apply.

Article 13

This Regulation shall enter into force on the day following its publication in the "Official Gazette of the Republic of North Macedonia" and shall start to apply from 1 September 2025.

No. 10-749/1

Director General

02 June 2025

Civil Aviation Agency

Skopje

Dragi Stojanoski

ATTACHMENT

The special requirements, for the aviation personnel medical fitness Class 4, as well as the special requirements, manner and procedure for conducting aero-medical assessments, oversight of medical assessment and obtaining appropriate certificates for conducting aero-medical assessments to Class 4 personnel

1. General

This Attachment stipulates the special requirements, for the aviation personnel medical fitness Class 4 including personal not covered by Class 1,2 and 3, and is subject to aero-medical assessments in accordance with the regulations for the relevant aviation personnel.

The requirements and rules in this document are not by themselves sufficiently detailed to cover all possible individual situations. It is therefore necessary to leave many decisions relating to the assessment of medical fitness to the discretion and choice of the authorized aero-medical examiner (AME), with the support of the competent authority (AMS). The assessment must therefore be based on a medical examination, carried out in full accordance with the highest standards of medical practice. Due regard must also be paid to the privileges granted by the certificate (licence/authorisation) applied for or held by the applicant for a medical certificate and the conditions under which the holder of the certificate will exercise those privileges in the performance of the assigned duties. If there are clinical indications, further testing to that described in this document should be carried out under the guidance of an appropriate specialist.

2. *Specific requirements for aero-medical centres, authorized aero-medical examiner and occupational health medical practitioners (OHMPs)*

The specific requirements to be met by aero-medical centers, an authorized aero-medical examiner are laid down in EU Regulation 1178/2011.

The occupational health medical practitioners (OHMPs) may carry out medical assessments examinations of Class 4 personnel provided that:

- a) they are fully qualified and licensed in the practice of medicine and qualified in occupational medicine;
- b) the in-flight working environment and safety duties of Class 4 were included in their occupational medicine qualification syllabus or other training or operational experience;
- c) they have notified the Civil Aviation Agency (hereinafter: competent authority – AMS) before starting such activity.

3. *Competent Authority (AMS)*

The competent authority - AMS must have one or more medical practitioners experienced in the practice of aviation medicine. The competent authority (AMS) is solely responsible for technical medical matters.

Medical confidentiality shall be respected at all times. The authorised aero-medical examiner (AME) shall ensure that all oral and written reports and electronically stored information on medical matters concerning licence holders/applicants are made available to the competent authority (AMS) for performing medical assessments.

4. *The special requirements, manner and procedure for conducting aero-medical assessments for Class 4 personnel*

Holders of a Class 4 medical certificate are required to have a minimum standard of medical fitness to ensure that they are fit to perform their duties and to minimise as far as possible the risk of them becoming suddenly incapacitated to such an extent that the flight safety could be jeopardised.

Personnel classified in Class 4 must meet the following medical fitness requirements:

- satisfy the general medical conditions required for the acquisition of the status of worker and
- not suffer from acute or chronic diseases or conditions which aggravation could affect the safe performance of duties and thereby endanger flight safety.

When a person uses mechanical and electro-mechanical aids to meet the required standard for the issue of a medical certificate, they shall be functionally tested in an operational environment by an authorised aero-medical examiner (AME). It may also be

necessary for an appropriate medical specialist to assess the person using the aid in an operational environment.

The applicant for a Class 4 medical certificate shall provide to the authorised aero-medical examiner (AME) with a personally certified medical information statement relating to personal, family and hereditary history. The applicant shall be made aware of the need to provide a statement which is as complete and accurate as the applicant's knowledge permits.

A person undergoing a medical examination for the purpose of determining medical fitness shall be required to submit medical documentation of his medical fitness, provided by the medical examiner. The documentation shall include, *inter alia*, any changes in his medical condition since the last examination.

The authorized medical examiner (AME) or occupational health medical practitioners (OHMP) shall notify the competent authority of any individual case in which there is doubt about the candidate's ability to meet any requirement. In such circumstances, the competent authority may decide whether the medical certificate should be issued or revoked.

When the competent authority is satisfied that the requirements of this Part are met, the applicant shall be issued with a Class 4 medical certificate by an authorized medical examiner (AME) in the form and content given in Form 1 of this Attachment. A Class 4 medical certificate shall be issued for a maximum period of 5 years.

The requirements to be met for revalidation/renewal of a Class 4 medical certificate shall be the same as those for the initial certificate, unless otherwise specified.

Except as otherwise specified in this Part, the holders of Class 4 medical certificates shall renew or revalidate Class 4 medical certificates at most every 5 (five) years.

If an applicant does not fully meet the medical fitness requirements specified in this Attachment for a particular licence/authorisation, the medical certificate shall not be issued, revalidated or renewed, but the decision shall be left to the competent authority - AMS. If the prescribed medical fitness requirements provide that an applicant may be assessed as fit under special circumstances, the competent authority may do accordingly. This medical fitness assessment may be performed by the Aero Medical Centre (AMC), the authorized medical examiner (AME) or the occupational health medical practitioners (OHMP) in consultation with the competent authority.

The Aero Medical Centre (AMC), the authorized medical examiner (AME) or the occupational health medical practitioners (OHMP) who assess that the candidate is medically fit, shall notify the competent authority of the details of the assessment.

A medical certificate may be issued, revalidated/extended or renewed by the Aero Medical Centre (AMC), the authorized medical examiner (AME) or the occupational health medical practitioners (OHMP) after authorised entity - AMS has considered the requirements and guidance material, the opinion of an aero medical expert and, if necessary, the opinion of other relevant experts familiar with the operational/work environment as well as:

- (1) the medical deficiencies in relation to the work environment;
- (2) the applicant's ability, skill and experience in the relevant work environment;
- (3) on the job medical examination, if necessary, and
- (4) the condition for the application of any limitations to the medical certificate and licence.

When more than one limitation is required for the issuance of a medical certificate, the competent authority AMS must consider the additional and mutual effects on the safety of operation before issuing the certificate.

5. *Secondary review*

A request for a secondary review procedure, the form and content of which are defined in Medical Document No. 12 of this Attachment, shall be submitted to the competent authority within 15 days from the date of receipt of the notification of the performed examination in accordance with Article 119 paragraph (4) of the Aviation Law.

The competent authority - AMS, within 15 days from the date of receipt of the request, shall form the Aviation Commission of Second Instance, which shall have a chairman and two members who are authorized medical examiners (AME) for assessment of medical fitness. The authorized individual medical examiner who performed the examination for which a request for a secondary review procedure has been submitted may not participate in this Commission.

The second-instance aviation committee must keep a record, with the format and content defined in Medical Document No. 13 of this Attachment, and the procedure ends with a decision, which is submitted to the applicant/holder of the medical certificate and to the Aero Medical Centre (AMC), the authorized medical examiner (AME) or the occupational health medical practitioners (OHMP).

If the applicant/holder of the medical certificate during the secondary review procedure is assessed as medically fit, he shall be issued with a Class 4 medical certificate. If the applicant/holder of the medical certificate in the secondary review procedure is assessed as medically unfit, the Class 4 medical certificate shall be withdrawn.

6. Variations in conditions and guidance

The medical certificate is valid at most from the date of issue to the date in the month of expiry (from date to date).

For licence/rating holders of Class 4 medical certificate who have reached their 50th (fiftieth) birthday, the maximum period of five years specified in point 4 shall be reduced to a maximum of four years. For licence/rating holders of a Class 4 medical certificate who have reached their 60th (sixtieth) birthday, the maximum period of four years shall be reduced to a maximum of three years.

A medical certificate may be issued if it is unlikely that the applicant's ability to exercise the privileges of the licence to the required level of safety will be jeopardised.

If, during regular medical examinations, a medical condition is determined that deviates from the category of physical and mental capabilities prescribed by this Regulation, the person may be declared fit by the competent authority - AMS:

- if his medical condition is such that it does not make him incapable of performing his duties;
- if his possible deficiencies are functionally compensated;
- if his professional ability, skills and experience are such that they can compensate for the determined deficiency.

If a regular medical examination determines that he has a health condition that requires a special procedure, a medical certificate may be issued, with certain restrictions (shortening the validity period of the issued medical certificate, restrictions on the performance of certain special professional tasks, the use of glasses while performing the tasks and other restrictions).

MEDICAL DOCUMENT NO. 1:
APPLICATION FOR OBTAINING MEDICAL CERTIFICATE

**APPLICATION FOR OBTAINING AVIATION PERSONNEL
MEDICAL CERTIFICATE
Medical document No. 1**

The application must be filled in block letters and legibly.

CONFIDENTIAL
PROFESSIONAL SECRET
Medical Diary No. _____

(1) Member State	(2) Class of medical fitness certificate for which the application is submitted:			
	<input type="checkbox"/>	CLASS 4		
(3) Last name:	(4) Previous surname:		(12) I submit the application	
			<input type="checkbox"/>	FIRST TIME
			<input type="checkbox"/>	RENEWAL
(5) Name:	(6) Date at birth	(7) Gender		(13) File/Document number
		<input type="checkbox"/>	Male	
		<input type="checkbox"/>	Female	
(8) Place and country of birth:	(9) Citizenship:		(14) Type of document for which the application is submitted:	
(10) Permanent residential address:	(11) Temporary address of residence:		(15) Occupation (primary)	
Country of permanent residence:	Country of temporary residence:		(16) Employer	
Telephone number at permanent residence:	Telephone number at temporary residence:		(17) Last medical examination	
			Date:	
			Place:	
(18) Certificates you hold (type):			(19) Conditions/limitations/ deviations in the document/ the medical certificate	

Certificate number:		NO <input type="checkbox"/> YES <input type="checkbox"/>	
Country of issue:		Details:	
(20) Have you ever had medical certificate not issued, revoked or restricted by the competent authority medical body (entity)?	(21) Total flying:	(22) Total flying from the last review:	
NO <input type="checkbox"/> YES <input type="checkbox"/> Date: _____ Place: _____ Details:	(23) Aircraft with which you currently fly:		
(24) Aerospace accident / misfortune from the latter review:	(25) Type of flight you intend to undertake:		
NO <input type="checkbox"/> YES <input type="checkbox"/> Date: _____ Place: _____ Details:	(26) Flying activity at the moment:		
(27) Alcohol - to indicate the average weekly quantity:	(28) Current medication use:		
	NO <input type="checkbox"/> YES <input type="checkbox"/>		
(29) Do you smoke tobacco:	To indicate the name of the medicine, the dose, the time of taking and the reason:		
NEVER <input type="checkbox"/>			
NO <input type="checkbox"/> Termination date: _____			
YES <input type="checkbox"/> Specify the type and quantity:			

General information and medical history: Do you have any knowledge of the following? YES or NO (as appropriate) must be checked in each box.
Affirmative answers require clarification in the comments section.

General data and history of the disease	YES	NO	General data and history of the disease	YES	NO
101 Eye problems/eyes surgery			118 Psychological and spiritual disorders		
102 Wearing glasses and/or contact lenses (so far)			119 Alcohol/drug/medication abuse		
103 Changes in eyeglass prescription since last check-up			120 Suicide attempt		
104 Allergy/pollen fever			121 Motion sickness requiring medication		
105 Asthma, lung diseases			122 Anemia/sickle cell anemia stations/others disorders		
106 Heart and arteriovenous problems			123 Malaria or other tropical diseases		
107 High or low blood pressure			124 Positive HIV test		
108 Kidney stone or blood in the urine			125 Sexual portable diseases		
109 Diabetes, hormonal disorders			126 Hospitalized - admitted in hospital		
110 Stomach, liver and intestinal problems			127 Others illnesses/injuries		
111 Hearing, hearing disorders			128 Doctor home visit from the last check		
112 Diseases of the throat, nose or speech disorder			129 Refusal to accept a life insurance by an insurance company		
113 Head injuries/contusions			130 Failure to issue a flight permit		

114 Frequent and severe headaches			131 Discharged from military service for medical reasons		
115 Dizziness or fainting			132 Disability benefit, pension or severance pay due to injury or illness		
116 Loss of consciousness caused by any cause					
117 Neurological disorders: epilepsy/stroke/paralysis or similar.					
Family diseases	YES	NO	Family diseases	YES	NO
133 Heart diseases			138 Diabetes		
134 High bloody pressure			139 Tuberculosis		
135 High cholesterol			140 Allergy / asthma / eczema		
136 Epilepsy			141 Hereditary disorders		
137 Soulful diseases			142 Glaucoma		
FOR WOMEN ONLY					
1 43 Gynaecological or menstrual problems			Last gynaecological check (date) _____		
1 44 Are you pregnant?					
(30) Note: To be confirmed if previously stated and no changes.					

PRIMARY HEALTH CARE PHYSICIAN			
Name and surname:		Number	
Office (correct name):			
Address:			
Phone / Fax / Email:			

(31) I declare under criminal and material responsibility that I have conscientiously, responsibly and truthfully reviewed this form and that I have not withheld any fact or statement that could mislead anyone or lead to a wrongful conclusion. I accept that giving untrue data related to this request or not providing the following health documentation, may result in non - issuance of health certificate or termination of already issued medical certificate and that I am aware for everyone legally consequences.

ACCEPTANCE OF ACCESS TO HEALTH DATA:
I authorize the transfer of all the above data and attachments to the AME, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the competent authority with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.

<hr/>	<hr/>	<hr/>
Date	Signature of the candidate	Signature of the AME (of the witness)

MEDICAL DOCUMENT NO. 2

MEDICAL EXAMINATION REPORT FROM THE MEDICAL COMMISSION CHAIRMAN

MEDICAL EXAMINATION REPORT Medical document No. 2

DATE OF CHECKUP: _____

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No. Medical Diary _____

APPLICANT'S NAME AND SURNAME:				DATE AND PLACE OF BIRTH:		Type of document:	
CLASS:	<input type="checkbox"/> 4						
(201) CHECKUP:		<input type="checkbox"/> FIRST-SELECTED		<input type="checkbox"/> STANDARD		<input type="checkbox"/> EXTENDED	
						<input type="checkbox"/> ADDITIONAL	
(202) HEIGHT:	(203) WEIGHT:	(204) EYES COLOUR:	(205) HAIR COLOUR:	(206) Bloody pressure: mm Hg		(207) Pulse in idle:	
cm	kg						
				SYSTOLIC	DIASTOLIC	SPEED	RHYTHM

Clinical examination: Check of each item	Normal	Deviation	Clinical examination: Check of each item	Normal	Deviation
(208) Head, face, neck,			(218) Abdomen, hernias, black liver, spleen		
(209) Mouth, throat, teeth			(219) Anus, rectum		
(210) Nose, sinuses			(220) Genito-urinary system		
(211) Ears, eardrums			(221) Endocrine system		
(212) Eyes-orbit and adnexa, visual field			(222) Upper and lower extremities, joints		
(213) Eye-pupils and fundus on the eye			(223) Pelvis and the rest of the musculoskeletal system		
(214) Eye-eye movements, nystagmus			(224) Neurological reflexes etc.		
(215) Lungs, chest, breasts			(225) Psychiatric		
(216) Heart			(226) Skin, scars and lymph nodes		
(217) Veno-arterial system			(227) General		
(228) NOTE: Each deviation to be described. Before each opinion <i>i.e.</i> , comment the item number should be entered.					

VISUAL ACUITY											
(229) Distance type: 5m/6m			CORRECTED		(230) Medium distance type H 14 at a distance of 100 cm			UNCORRECTED		CORRECTED	
UNCORRECTED			GLASSES	CONTACT LENSES				YES	NO	YES	NO
RIGHT EYE					RIGHT EYE						
LEFT EYE					LEFT EYE						
BOTH EYES					BOTH EYES						
(232) GLASSES					(231) Short distance type H 5 at a distance of 30-50 cm						
<input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: _____											
(233) CONTACT LENSES					RIGHT EYE						
<input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: _____					LEFT EYE						
					BOTH EYES						
REFRACTION	Sphere	Cylinder	Axle	Proximity							
RIGHT EYE											
LEFT EYE											

COLOUR RECOGNITION											
Pseudoachromatic tables:						Type:					
Number on table:						Number on errors:					
<input type="checkbox"/> NORMAL			<input type="checkbox"/> DEFERRAL			<input type="checkbox"/> NORMAL			<input type="checkbox"/> DEFERRAL		
(234) HEARING				RIGHT EAR		LEFT EAR		(235) URINE ANALYSIS			
Examination with conversation at 2 m with turned back towards the examiner				<input type="checkbox"/> YES		<input type="checkbox"/> YES		<input type="checkbox"/> NORMAL		<input type="checkbox"/> WAIVER	
				<input type="checkbox"/> NO		<input type="checkbox"/> NO					
AUDIOMETRY						GLUCOSE		PROTEIN		BLOOD	
Hz		500	1000	2000	3000	4000	8000				
RIGHT											
LEFT											
(236) LUNG FUNCTION						(237) HAEMOGLOBIN					
Expiratory flow l/m						g/ dl					
<input type="checkbox"/> NORMAL			<input type="checkbox"/> WAIVER			<input type="checkbox"/> NORMAL			<input type="checkbox"/> WAIVER		
ASSOCIATED REPORTS AND FINDINGS						THEY ARE NOT MADE		NORMAL		WAIVER	
(238) ECG											
(239) Audiogram											
(240) Ophthalmological report											
(241) ENT report											
(242) RTG on the lungs											
(243) Lipids in the blood											
(244) Functional lung examination											
(245) EEG											
(246) neuropsychiatric and internist reports											
Other:											
(247) RECOMMENDATION OF THE AUTHORIZED DOCTOR FOR THE EXAMINATION OF AVIATION PERSONNEL											
<input type="checkbox"/>	Capable for class: 4										
<input type="checkbox"/>	Issued Medical certificate of health ability for the class: _										
<input type="checkbox"/>	Incapable for class: _____ in accordance with _____										
<input type="checkbox"/>	Deferred assessment. Why and to whom is it addressed?										
(248) NOTES, WARNINGS, LIMITATIONS											
(249) STATEMENT BY AME - CHAIRMAN OF THE MEDICAL COMMISSION											
I hereby confirm that I/the Committee I chair with, have examined the applicant named in this Medical Examination Report and that this Report, with all attachments, includes my findings in full.											

A legal or natural person who has the authority to:	Signature and seal of the AME - the Chairman of the Medical Committee
Doctor's name and surname (in capital letters):	
Procedure completion date:	Phone / Fax:

THE APPLICANT PICKED UP THE MEDICAL CERTIFICATE OF MEDICAL FITNESS ON DAY: _____	
SIGNATURE OF THE PERSON PROVIDING THE MEDICAL CERTIFICATE	APPLICANT'S SIGNATURE

MEDICAL DOCUMENT NO. 3
OPHTHALMOLOGY EXAMINATION REPORT

OPHTHALMOLOGY EXAMINATION REPORT

Medical document No. 3

DATE OF CHECKUP: _____

CONFIDENTIAL - PROFESSIONAL SECRET

No. Medical Diary _____

APPLICANTS' NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
<p>(301) CONSENT TO RELEASE HEALTH DATA: I release all data from this Report and Annex to the authorized aero medical examiner, to the competent authority of the RNM, and where necessary, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the above mentioned with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.</p>					
_____ Date		_____ Candidate's signature		_____ Signature of the doctor (witness)	
(302) CHECKUP	<input type="checkbox"/> FIRST-SELECTED	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
CLASS	<input type="checkbox"/> 4				

(303) Ophthalmological history of the disease:

Clinical examination: Checking each item	NORMAL	DEVIATION	Clinical examination: Checking each item	NORMAL	DEVIATION
(304) Eyes, outer part and eyelids			(308) Pupillary reflexes		
(305) Eyes, external part			(309) Fundus (Ophthalmoscopy)		
(306) Eye position and movement			(310) Convergence	cm	
(307) Visible field, confrontation			(311) Accommodation	D	

(312) BALANCE OF OCCUPATIONAL MUSCLES (in prism dioptries)

DISTANCE 5 /6 m		DISTANCE 30 -50 cm	
ORTHO			
ESO			
EXO			
HYPER			
CYCLE			
TROPHY	<input type="checkbox"/> YES <input type="checkbox"/> NO	FORIA	<input type="checkbox"/> YES <input type="checkbox"/> NO
TESTING THE FUSION RESERVE	<input type="checkbox"/> NOT MADE <input type="checkbox"/> NORMAL <input type="checkbox"/> DEVIATION		

(313) COLOUR RECOGNITION

Pseudoisochromatic tables:	Type:
----------------------------	-------

Number on table:			Number on errors:
Indicated additional testing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Method:	
<input type="checkbox"/> SAFE COLOUR VISION <input type="checkbox"/> UNSAFE COLOUR VISION			

VISUAL ACUITY

(314) DISTANCE TYPE 5m/6m		CORRECTED TO:	
UNCORRECTED:		GLASSES	CONTACT LENSES
RIGHT EYE			
LEFT EYE			
BOTH EYES			
(315) TYPE OF DISTANCE OF 1 m			
RIGHT EYE			
LEFT EYE			
BOTH EYES			
(316) TYPE OF DISTANCE FROM 30-50 cm			
RIGHT EYE			
LEFT EYE			
BOTH EYES			

(317) REFRACTION	Sphere	Cylinder	Axle	Proximity
RIGHT EYE				
LEFT EYE				
<input type="checkbox"/> REFRACTION DETERMINED DURING THE EXAMINATION		<input type="checkbox"/> REFRACTION DETERMINED ON THE BASIS OF PRESCRIPTION		

(318) GLASSES	(319) CONTACT LENSES
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TYPE: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TYPE: _____

(320) INTRAOCULAR PRESSURE	
Right (mm) Hg)	Left (mm) Hg)
METHOD:	<input type="checkbox"/> NORMAL <input type="checkbox"/> DEVIATION
METHOD	<input type="checkbox"/> NORMAL <input type="checkbox"/> DEVIATION

(321) OPHTHALMOLOGICAL NOTES AND RECOMMENDATIONS:

(322) STATEMENT OF THE DOCTOR - MEMBER OF THE MEDICAL COMMISSION
I hereby confirm that I/the member of the Commission, have examined the candidate named in this Ophthalmological Examination Report, and that this Report with all attachments including my findings is complete and reliable.

A legal or natural person who has the authority to:	Signature and stamp of the doctor - ophthalmologist:	Signature and seal Chairman of the Medical Committee
Name and surname of the doctor - ophthalmologist (in capital letters)		
Procedure completion date:	Telephone / Fax:	

MEDICAL DOCUMENT NO. 4
ENT EXAMINATION REPORT

ENT EXAMINATION REPORT
Medical document No. 4

DATE OF CHECKUP: _____ **CONFIDENTIAL - PROFESSIONAL SECRET**
No. Medical Diary _____

APPLICANTS' NAME AND SURNAME		DATE AND PLACE OF BIRTH:		Type of document:	
<p>(401) CONSENT TO RELEASE HEALTH DATA: I release all data from this Report and Annex to the authorized aero medical examiner, to the competent authority of the RNM, and where necessary, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the above mentioned with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.</p>					
_____		_____		_____	
Date		Signature of the candidate		Signature of the doctor (witness)	
(402) CHECKUP	<input type="checkbox"/> FIRST -SELECTIVE	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
CLASS	<input type="checkbox"/> 4				

(403) Otolaryngological history on the disease:

Clinical examination: Checking each item	Normal	Deviation	Clinical examination: Checking each item	Normal	Deviation
(404) Head, face, neck, vertex			(409) Speech		
(405) Oral cavity, teeth			(410) Sinus		
(406) Gorge			(411) Auditory part, Tympanic membrane		
(407) Nasal passages, nasopharynx, anterior rhinoscopy			(412) Pneumatic otoscopy		
(408) Vestibular composition, including Romberg test			(413) Impedance tympanometry, including Valsalva procedure (only at FIRST SELECTION examination)		

Additional examinations (according to indications):	NOT MADE	NORMAL	DEVIATION
(414) Spoken audiometry			
(415) Side rhinoscopy			
(416) ENG, spontaneous and positional nystagmus			
(417) Calories or rotary test			
(418) Mirror or fibre laryngoscopy			

(419) PURE TONE AUDIOMETRY			(420) AUDIOGRAM								
dB HL (HEARING THRESHOLD)			O = RIGHT, J = LEFT, = AIR, >>> = BONE								
Hz	RIGHT EAR	LEFT EAR	DB /HL								
250			-10								
500			0								
1000			10								
2000			20								
3000			30								
4000			40								
6000			50								
8000			60								
			70								
			80								
			90								
			100								
			110								
			120								
			Hz 250 500 1000 2000 3000 4000 6000 8000								

(421) OTLORAGINGOLOGICAL NOTES AND RECOMMENDATIONS:

(422) STATEMENT OF THE DOCTOR - MEMBER OF THE MEDICAL COMMISSION		
I hereby confirm that I/the member of the Commission, have examined the candidate named in this Otorhinolaryngological Examination Report, and that this Report with all attachments, including my findings, is complete and reliable.		
A legal or natural person who has the authority to:	Doctor's signature and stamp - otorhinolaryngologist:	Signature and seal Chairman of the Medical Committee
Name and surname of the doctor - otorhinolaryngologist (with big letters)		
Procedure completion date:	Telephone/Fax:	

MEDICAL DOCUMENT NO. 5
NEUROLOGICAL EXAMINATION REPORT

NEUROLOGICAL EXAMINATION REPORT
Medical document No. 5

DATE OF CHECKUP: _____ **CONFIDENTIAL - PROFESSIONAL SECRET**
No. Medical Diary _____

APPLICANTS' NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
<p>CONSENT TO RELEASE HEALTH DATA: I release all data from this Report and Annex to the authorized aero medical examiner, to the competent authority of the RNM, and where necessary, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the above mentioned with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.</p> <p>_____ Date _____ Candidate's signature _____ Signature of the doctor (witness) _____</p>					
CHECKUP	<input type="checkbox"/> FIRST -SELECTIVE	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
CLASS	<input type="checkbox"/> 4				

Neurological history of the disease -anamnesis (head injuries, fainting, dizziness, blurred vision, treatment in an outpatient clinic and/or at a doctor's office, epilepsy , etc.) :

Neurological status:

BRAIN NERVES	MYOTATIC REFLEXES
MOTOR COMPOSITION	PATHOLOGICAL REFLEXES
COORDINATION	EEG
MUSCLE TONE	ADDITIONAL REVIEWS AND ANALYSES
SENSITIVITY	
OPINION	

Neurological notes and recommendations:

(422) STATEMENT OF THE DOCTOR - MEMBER OF THE MEDICAL COMMISSION

I hereby confirm that I/the member of the Commission have, examined the candidate named in this Neurological Examination Report, and that this Report with all attachments, including my findings, is complete and reliable.

Name and surname of the doctor - neurologist (in capital letters)	Doctor's signature and stamp - neurologist :	Signature and seal Chairman of the Medical Committee
Procedure completion date:	Telephone / Fax:	

MEDICAL DOCUMENT NO. 6
PSYCHIATRIC EXAMINATION REPORT

PSYCHIATRIC EXAMINATION REPORT
Medical document No. 6

DATE OF REVIEW: _____

CONFIDENTIAL - PROFESSIONAL SECRET

No. Medical Diary _____

APPLICANTS' NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
<p>CONSENT TO RELEASE HEALTH DATA: I release all data from this Report and Annex to the authorized aero medical examiner, to the competent authority of the RNM, and where necessary, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the above mentioned with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.</p>					
_____		_____		_____	
Date		Signature of the candidate		Signature of the doctor (witness)	
CHECKUP	<input type="checkbox"/> FIRST -SELECTIVE	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
CLASS	<input type="checkbox"/> 4				

Neurological history of the disease -anamnesis (head injuries, fainting, dizziness, blurred vision, treatment in an outpatient clinic and/or at a doctor's office, epilepsy, etc.) :

PSYCHIATRIC EXAMINATION (INTERVIEW):

1. HISTORY

- prenatal and perinatal history, early childhood,

2. MENTAL STATUS

OPINION

Psychiatric opinion, notes and recommendations:

(422) STATEMENT OF THE DOCTOR - MEMBER OF THE MEDICAL COMMISSION

I hereby confirm that I/the member of the Commission, have examined the candidate named in this Psychiatric Examination Report, and that this Report with all attachments, including my findings, is complete and reliable.

Name and surname of the doctor - psychiatrist (in capital letters)	Doctor's signature and stamp - the psychiatrist:	Signature and seal Chairman of the Medical Committee
Procedure completion date:	Telephone / Fax:	

MEDICAL DOCUMENT NO. 7
PSYCHIATRIC EXAMINATION REPORT

PSYCHOLOGICAL EXAMINATION REPORT
Medical document No. 7

DATE OF REVIEW: _____

CONFIDENTIAL - PROFESSIONAL SECRET

No. Medical Diary _____

APPLICANTS' NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
<p>CONSENT TO RELEASE HEALTH DATA: I release all data from this Report and Annex to the authorized aero medical examiner, to the competent authority of the RNM, and where necessary, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the above mentioned with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.</p>					
_____		_____		_____	
Date		Signature of the candidate		Signature of the doctor (witness)	
CHECKUP	<input type="checkbox"/> FIRST -SELECTIVE	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
CLASS	<input type="checkbox"/> 4				

Indications for psychological processing:

Biographical data (family, education, socioeconomic status, job advancement, critical health, diseases)

Cognitive abilities

Psychological functions

Features of the person

Interviews

Opinion

Psychologist's notes and recommendations:

(422) STATEMENT OF THE DOCTOR - MEMBER OF THE MEDICAL COMMISSION

I hereby confirm that I/the member of the Commission, have examined the candidate named in this Psychological Examination Report, and that this Report with all attachments, including my findings, is complete and reliable.

Name and surname of the doctor - psychologist (in capital letters)	Doctor's signature and stamp - the psychologist:	Signature and seal Chairman of the Medical Committee
Procedure completion date:	Telephone / Fax:	

MEDICAL DOCUMENT NO. 8
INTERNAL CHECKUP REPORT

INTERNAL CHECKUP REPORT
Medical document No. 8

DATE OF CHECKUP: _____ **CONFIDENTIAL - PROFESSIONAL SECRET**

No. Medical Diary _____

APPLICANTS' NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
<p>CONSENT TO RELEASE HEALTH DATA: I release all data from this Report and Annex to the authorized aero medical examiner, to the competent authority of the RNM, and where necessary, the competent authority and, where necessary, to the aviation medical authority of another country, so that the data or the electronically stored data could be used for the assessment of medical fitness. The data obtained remain in the possession of the above mentioned with the possibility of my access to them or access by my primary care physician according to legal regulations. Medical professional secrecy will be respected throughout the period.</p> <p>_____ Date _____ Candidate's signature _____ Signature of the doctor (witness) _____</p>					
CHECKUP	<input type="checkbox"/> FIRST -SELECTIVE	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
CLASS	<input type="checkbox"/> 4				

Internist history on the disease:

Internist status:

SKIN AND MUCOSA				ABDOMEN	
HEAD AND NECK				ENDOCRINE SYSTEM	
RESPIRATORY SYSTEM				ECG DATA, ERGOMETRY	
CARDIOVASCULAR SYSTEM				RO PULMO : SCOPE GRAPH	
TIME OF	SEATED	LAI D	20 PUSH UPS	2 MINUTES	
APNEA: TA					
PULSE					
LABORATORY FINDINGS:		HEMOGRAM:		Se	HP
Urine:	Sp.t	Alb		Sit	
		Sach			

OPINION

Notes and recommendations of the internist:

(422) STATEMENT OF THE DOCTOR - MEMBER OF THE MEDICAL COMMISSION

I hereby confirm that I/the member of the Commission, have examined the candidate named in this Internist Examination Report, and that this Report with all attachments, including my findings, is complete and reliable.

Name and surname of the doctor - internist (in capital letters)	Doctor's signature and stamp - internist:	Signature and seal Chairman of the Medical Committee
Procedure completion date:	Telephone / Fax:	

MEDICAL DOCUMENT NO. 9
INSTRUCTIONS FOR ADDITIONAL REVIEW
WITH A REPORT FROM AN EXPERT ACCEPTABLE TO THE MINISTRY OF HEALTH

INSTRUCTIONS FOR ADDITIONAL REVIEW
WITH A REPORT FROM AN EXPERT ACCEPTABLE TO THE MINISTRY OF HEALTH
Medical document No. 9

DOCTOR-SPECIALIST (NAME AND SURNAME)		
HEALTH FACILITY		
Address/phone:		

APPLICANTS' NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
CLASS	<input type="checkbox"/> 4				
CHECKUP	<input type="checkbox"/> FIRST -SELECTIVE	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
Review start date:					

Reason because this checkup is performed:
Requirements:
Attached medical documentation:

A legal or natural person who what there is authorization:	
First and last name (in capital letters)	Signature and seal of the AME - Chairman of the Medical Committee:
Address:	Telephone / Fax:

<p align="center">ADDITIONAL REVIEW REPORT Medical Document No. 9 - CONTINUED</p>

APPLICANTS` NAME AND SURNAME:		
TYPE OF REVIEW:		
Date on the review:		
DOCTOR:		
Address:		
Phone / Fax / Email:		

Finding and opinion:

Name and surname of the doctor:	Doctor 's signature and stamp:
Review completion date:	

MEDICAL DOCUMENT NO. 10
ANNUAL REPORT OF THE MEDICAL COMMISSION

**ANNUAL REPORT OF THE MEDICAL COMMISSION FOR DETERMINING THE
HEALTH FITNESS OF AVIATION PERSONNEL
Medical document No. 10**

FOR _____ YEAR

FOR GRADE 4

NAME:	
ADDRESS:	
PHONE/FAX:	

1. NUMBER OF INSPECTIONS PERFORMED*			
		CAPABLE	NOT CAPABLE
FIRST-SELECTION			
REGULAR			
EXTRAORDINARY			
TOTAL			
* To be specified in the appendix names and surnames as well as the reasons for incapacity that will be determined during the examinations for the extension of the validity of the Health Certificate ability			
2. The conditions for medical work of the medical centre Commission and conclusions in correlation with monitoring the aviation personnel population			
3. Accidents and incidents during the calendar year (number, consequences, causes).*			
4. Others activities and suggestions			
To be attached in the Appendix			

Place: _____

Date: _____

Chairman of the Medical Committee

MEDICAL DOCUMENT NO. 11
WORKBOOK OF THE MEDICAL COMMISSION

**WORKBOOK OF THE MEDICAL COMMISSION FOR DETERMINING AVIATION PERSONNEL
HEALTH FITNESS
Medical document No. 11**

[illegible]

MEDICAL DOCUMENT NO. 12
REQUEST FOR – SECONDARY REVIEW PROCEDURE

REQUEST FOR SECONDARY REVIEW PROCEDURE
Medical document No. 12

Name and surname: _____

Address: _____

Date and place of birth : _____

NAME: _____

Date on the doctor's checkup : _____

☐ I have been refused a Certificate of Medical Fitness.

CLASS	<input type="checkbox"/> 4
-------	----------------------------

☐ I have a restriction:

--

CONDITIONS THAT I DO NOT MEET:

Date of delivery of the Certificate/Notice:

--

Date of submission of the request:

--

Signature of the applicant:

--

MEDICAL DOCUMENT NO. 13
MINUTES OF THE COMMISSION OF SECOND INSTANCE

MINUTES OF THE COMMISSION OF SECOND INSTANCE Medical document No. 13	
Regarding the conclusion of the first instance court medical Committee on the subject:	
_____	from _____ year of birth _____
(name and surname) (place of birth)	
against the conclusion _____	(The first instance the doctor's office commission - Legal or natural person who has authorization)
number _____	from _____
	(date)
The minutes were drawn up on the day _____ in _____	
	(date and time) (place)
Authorized by the second-level Medical Commission:	
Chairman: _____	
(name and surname)	
Members: _____	

After medical examinations and reviewed medical documentation, namely:	

The Commission concluded that _____	
(name and surname)	
<input type="checkbox"/> SATISFIES <input type="checkbox"/> DOES NOT SATISFY	the health requirements for the class _____
and <input type="checkbox"/> IS CAPABLE <input type="checkbox"/> NOT CAPABLE	of performing the tasks

Members of the Commission:	
_____	Chairman of the Second Instance
_____	Medical Commission
_____	_____

MEDICAL DOCUMENT NO. 14
REQUEST FOR OPINION TO COMPETENT AUTHORITY - AMS

REQUEST FOR OPINION TO COMPETENT AUTHORITY - AMS
Medical document No. 14

MEDICAL COMMISSION _____

Address: _____

Phone / Email: _____

CANDIDATE'S NAME AND SURNAME:		DATE AND PLACE OF BIRTH:		Type of document:	
CLASS:	<input type="checkbox"/> 4				
(201) REVIEW	<input type="checkbox"/> FIRST- SELECTED	<input type="checkbox"/> STANDARD	<input type="checkbox"/> EXTENDED	<input type="checkbox"/> ADDITIONAL	
Date of commencement of the procedure:					

After the medical examination and the reviewed medical documentation, namely:

We are looking for opinion:

Signature and stamp of the doctor - Chairman of the Medical Committee:

--

Date: _____ Phone / Fax: _____

FORM NO. 1:
CERTIFICATE OF MEDICAL FITNESS FOR AVIATION PERSONNEL

NAME: _____

Address / Telephone / Fax _____

Authorization number _____

**CERTIFICATE OF MEDICAL FITNESS
FOR OPERATING AS AVIATION PERSONNEL**

Form number 1

(name and surname)

(date and place of birth)

After the examination the Medical Commission determined that

☐ COMPLIES

☐ NOT COMPLIES

With the prescribed conditions for :

☐ CLASS 4

☐ WITHOUT LIMITATION ☐ WITH LIMITATION

NUMBER, CODE AND CONTENT OF THE RESTRICTION

ARTICLE /ANNEX OF THE REGULATION TO WHICH THE RESTRICTION APPLIES

☐ CAPABLE

☐ NOT CAPABLE

To operate as:
(type of document)

Workbook number: _____

Workbook serial number: _____

Date on issuance:

Valid until :

Signature of the Chairman of the Medical Committee

SEAL

FORM NO. 2:
INFORMATION ON NON-COMPLIANCE WITH THE CONDITIONS
FOR ISSUING A MEDICAL FITNESS CERTIFICATE

**INFORMATION ON NON-COMPLIANCE WITH THE CONDITIONS
FOR ISSUING A MEDICAL FITNESS CERTIFICATE**

Form number 2

Name and surname: _____

Address: _____

Date and place of birth: _____

NAME: _____

Working book number: _____

Date on the doctor's review: _____

Health class ability for which the prescribed
requirements for issuing a Medical Health
Certificate are not fulfilled

☐ 4

CONDITIONS ARE NOT
MEET:

The assessment of your application for issuance of Medical Fitness Certificate and Medical Examination Report based on the above information shows that you do not meet the prescribed requirements for Class 4. Accordingly, your application for a Medical Fitness Certificate for Class 4 is refused. If you wish to appeal for a review of this Decision, you must contact the Civil Aviation Agency in writing within 15 days from the date of receipt of this information.

According to this assessment, you do not meet the prescribed conditions and are not capable of performing the work for the required class. The assessment of medical fitness and the Medical Fitness Certificate shall enter into force immediately, i.e. on the date of issue.

Date on delivery: _____

Signature of the Chairman of the Medical Committee

SEAL

FORM NO. 3:
INFORMATION ON INITIAL MEDICAL
AND/OR OPERATIONAL LIMITATION

**INFORMATION ON INITIAL MEDICAL
AND/OR OPERATIONAL LIMITATION**

Form number 3.

Name and surname: _____

Working book number: _____

Date on the doctor's checkup: _____

RESTRICTIONS GIVEN: _____

(limitation No. , code , content)

(limitation No. , code , content)

EXPLANATION:

The above-mentioned limitations (conditions or prohibitions) are recommended to the competent authority to entered in your Medical Fitness Certificate or in the licence (operational restrictions). If you have need of more clarifications about this limitation, contact the Civil Aviation Agency. If you do not agree with the application of these limitations, please contact the Civil Aviation Agency in writing, where you will receive instructions on the procedures to be followed in order to implement further audit.

Date: _____

Signature of the Chairman of the Medical Committee

SEAL
