Belize Department of Civil Aviation

AVIATION MEDICAL ASSESMENT

Section A. Applicant Data. **Applicant Type: Pilot** _____ **Air Traffic Controller** _____ **Authorized Student** _____		
1. License Nº:	1.1. Class:	1.2. Type:
2. First Name(s):	2.1. Surname(s):	
3. Address:		
4. Sex: ☐ **Male** ☐ **Female**	5. Blood Type: **RH**	
6. Date of Birth:	6.1. Nationality:	
7. Type of Identification: Social Security: ☐ Passport ☐ Other ☐ _____ Document Number :		
8. Height: Feet ____ Inches. ____	9.Weight: Lbs. ☐ Kgs. ☐	
10. Color of eyes:	11. Color of hair:	

Section B. Medical Certificate Data.

1. Medically certified by: First Time : ☐	Renewal: ☐	Con-validation: ☐
2. Expiration Date of current Medical (If applicable):	3. Employed By:	
3. Have you ever done a medical to carry out aeronautical functions: YES ☐ NO ☐		
4. Please give the following information Total Flight hours:	Total flight hours in the last 6 months :	
5. Type of aircraft flown: 5.1. Aeroplane: Turbo (Prop) ☐ Propeller ☐	5.2. HELICOPTER ☐	

Section C. Medical History.

1. Have you experienced one or more of the following symptoms? For each one write the details in the comments section?

SYMPTOMS AND CONDITIONS TO LOOK FOR	Yes	No	SYPMTOMS AND CONDITIONS TO LOOK FOR	Yes	No
Strong or frequent headaches	☐	☐	Nervous disorder of any kind	☐	☐
Dizziness or fainting	☐	☐	Consumption or habitual use of drugs or narcotics	☐	☐
Loss of memory by any cause	☐	☐	Excessive consumption of alcohol (Alcohol abuse)	☐	☐
Eye disorders that did not require use of corrective lens	☐	☐	Suicidal thoughts	☐	☐
Hay fever	☐	☐	Epilepsy or epileptic attacks	☐	☐
Asthma	☐	☐	Rejection for life insurance	☐	☐
Heart (cardiac) Disorders	☐	☐	Hospitalized during the past two years (For what reason)	☐	☐
High or low blood pressure	☐	☐	Aircraft accident	☐	☐
Stomach problems	☐	☐	Gynecologic and obstetric Infections	☐	☐
Kidney stones or Blood in the urine	☐	☐	Other accidents	☐	☐
Sugar or albumin in urine	☐	☐	Other illness	☐	☐
Dizziness due to movement that require use of drugs	☐	☐		☐	☐

2.Do you have a family history of any of the following disease : Diabetes: ☐ Cardio-vascular Diseases: ☐ Tuberculosis: ☐

3. Comments:

Section D. Applicants Medical Declaration.

I _____ hereby declare that the all of the information that I have declared on this form is True and correct to the best of my knowledge and understanding.

_____ Date and place of exam

_____ Applicants signature

Section E: Medical History

1.Physical appearance (complexion): Thin ☐ Medium built ☐ Robust ☐ Obese ☐ Body Mass Index (BMI) Value:

ELEMENTS TO EVALUATE	NORMAL Yes	NORMAL No	ELEMENTS TO EVALUATE	NORMAL Yes	NORMAL No
Head, face, neck and scalp	☐	☐	Vascular System	☐	☐
Nose	☐	☐	Abdomen and viscera (including hernia)	☐	☐
Sinuses	☐	☐	Anus and rectum (hemorrhoids, fistulas and prostate)	☐	☐
Mouth and throat	☐	☐	Endocrine System	☐	☐
Ears in general (Inner and outer canals)	☐	☐	Genital urinary system	☐	☐
Eardrums (Drilling)	☐	☐	General review of systems	☐	☐
Eyes in general (Fields of vision)	☐	☐	Spinal Column (musculoskeletal affections)	☐	☐
Ophthalmoscope review	☐	☐	Visible marks, scars and tattoos	☐	☐
Pupils (equality and reaction)	☐	☐	Skin and lymphatic system	☐	☐
Ocular mobility (parallel movement associated with Nystagmus)	☐	☐	Lungs and chest (including breasts)	☐	☐
Psychiatric evaluation (indicate any alteration of personality)	☐	☐	Upper and lower extremities (force, breathe of movements)	☐	☐

ARTERIAL PRESSURE

SEATED	Systolic:	**LYING**	Systolic:
	Diastolic:		Diastolic:

Pulse: Seated:

VISUAL ACUITY FAR

Snellen Far	NON CORRECTED	CORRECTED	% of visual efficiency
Right eye	20/	20/	
Left eye	20/	20/	
Both eyes	20/	20/	

HEARING

LOSS (dB)	MURMUR	CONVERSATION
Right ear	Meters ☐ feet ☐	Meters ☐ feet ☐
Left ear	Meters ☐ feet ☐	Meters. ☐ feet ☐

VISUAL ACUITY CLOSE

Snellen Close	NON CORRECTED	CORRECTED	% of visual efficiency
Right eye	20/	20/	
Left eye	20/	20/	
Both eyes	20/	20/	

AUDIOMETRY

LOSS (dB)	500	1000	2000	3000	4000
Right ear					
Left ear					

VISUAL ACUITY IN COLOR

Normal ☐	Abnormal ☐	
Prescription for lenses Right eye Left eye	Applicable ☐	Not applicable ☐
Presbyopia	yes ☐	No ☐

Section F: Laboratory analysis. Results to be written in reccomendation section G.

1. Hemoglobin	2. Urine analysis : sugar( ) Albumin ( ) Microscopic analysis( )		
3 Glucose:	4. BUN :	7. Radiography of thorax Normal ☐ Abnormal ☐:	
5. Cholesterol: (Values)	6. Creatinine :	8. E.K.G.: Normal ☐ Abnormal ☐:	9. Triglycerides:

Section G: Medical Recommendations:

1. In this section, you should note all abnormalities, recommendations and observations found during the laboratory analysis.

2.The applicant (is hereby declared) - IS ☐ fit from the point of view of this doctor to obtain a license for :
IS NOT ☐

Section G: Doctor's Summary

I certify that I have recognized the applicant named in this medical certification report, and that this report together with any annexes attached reveal test results that are faithful and true to the best of my professional knowledge and understanding .

Place and date of exam

Signature and seal of medical examiner

Belize Department of Civil Aviation

PSYCHIATRIC EVALUATION

NAME OF APPLICANT: _____

ADDRESS: _____

AGE: _____ DATE OF BIRTH: _____

SEX: _____ OCCUPATION: _____

RELIGION: _____

ASSESSMENT :

RECOMMENDATIONS:

_____ _____

APPLICANT SIGNATURE: DATE OF EXAMINATION:

_____ _____

AUTHORIZED EXAMINER NAME AUTHORIZED EXAMINER SIGNATURE: