CIVIL AVIATION AUTHORITY OF FIJI
ISO 9001:2015 Certified

Application for Medical Certificate

MD 101

A. Medical Questionnaire and Examination Form

Use black pen, BLOCK LETTERS and ✓ applicable boxes.

Original Issue ◯ Renewal ◯

Date of Examination: ☐☐ ☐☐ ☐☐☐☐

PART A - Applicant details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others ▸

Applicant's Name:

Licence Number:

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Age: ☐ Male ☐ Female

Residential Address:

Suburb/Town:

Postal Address: *(if different from above)*

Suburb/Town:

Phone — Business Hours: | Alternative Business Hours:

After Hours: | Alternative After Hours:

Mobile: | Mobile:

Email Address:

Does the applicant have a regular general practitioner? NO ◯ YES ◯ ▸ Name:

Address:

Does the applicant have a regular dentist? NO ◯ YES ◯ ▸ Name:

Address:

Total flying hours: *(to nearest hour)*

Hours flown in the last 6 months: *(to nearest hour) since last exam*

Employer: *(if professional pilot)*

PART B - Medical Type

Certificate applied for

Operations performed or intended

Class 1	Class 2	Class 3	Class 4
◯ Airline Transport Pilot	◯ Private Pilot	◯ Air Traffic Control Officer	◯ Aircraft Engineers
◯ Commercial Pilot	◯ Student Pilot	◯ Flight Service Officer	
	◯ Other		

PART C - Designated Aviation Medical Examiner (DAME) details

DAME Name: | Stamp Number: | Reg. Number:

Address:

E-mail: | Phone: | Mobile:

PART D - Medical History

Have you ever experienced any of the following? *(place a tick ✓ the correct answer, eg:* Yes ☑ No ☐ *)*

1. Eye or vision trouble — Yes ○ No ○
2. Needed new glasses or contact lenses since last CAAF medical examination — Yes ○ No ○
3. Eye or corneal surgery — Yes ○ No ○
4. Hay Fever — Yes ○ No ○
5. Middle ear infection — Yes ○ No ○
6. Sinusitis — Yes ○ No ○
7. Hearing trouble — Yes ○ No ○
8. Problems with balance — Yes ○ No ○
9. Any other Ears, Nose & Throat problems or surgery — Yes ○ No ○
10. Asthma or wheezing — Yes ○ No ○
11. Chronic cough — Yes ○ No ○
12. Any other lung problem — Yes ○ No ○
13. Any shortness of breath — Yes ○ No ○
14. Pulmonary embolism or deep vein thrombosis — Yes ○ No ○
15. Coughed or vomited blood — Yes ○ No ○
16. Any severe allergy — Yes ○ No ○
17. Heart problem — Yes ○ No ○
18. Vascular problem — Yes ○ No ○
19. Suffered any chest pain — Yes ○ No ○
20. Rheumatic fever — Yes ○ No ○
21. High or low blood pressure — Yes ○ No ○
22. Severe abdominal pain — Yes ○ No ○
23. Hernia — Yes ○ No ○
24. Oesophagus, stomach, or intestinal troubles — Yes ○ No ○
25. Liver or Gall bladder problems — Yes ○ No ○
26. Diagnosed or treated for cancer, tumour, growth or malignancy *(including skin cancer)* — Yes ○ No ○
27. Anaemia or blood disease — Yes ○ No ○
28. Headaches/migraines which have interfered in any way with daily living? — Yes ○ No ○
29. Headaches/migraines requiring medication? — Yes ○ No ○
30. Dizziness or fainting spell — Yes ○ No ○
31. Unconsciousness for any reason — Yes ○ No ○
32. Head injury — Yes ○ No ○
33. Seizures/fits — Yes ○ No ○
34. Stroke — Yes ○ No ○
35. Paralysis — Yes ○ No ○
36. Any other neurological disorder — Yes ○ No ○
37. Diagnosed depression — Yes ○ No ○
38. Anxiety disorder/panic disorder — Yes ○ No ○
39. Learning difficulty — Yes ○ No ○
40. Attention deficit or hyperactivity disorder — Yes ○ No ○
41. Post traumatic stress disorder — Yes ○ No ○
42. Suicide attempt — Yes ○ No ○
43. Any other mental illness — Yes ○ No ○
44. Substance dependence or substance abuse — Yes ○ No ○
45. Use of legal or illegal recreational drugs or substance — Yes ○ No ○
46. Alcohol dependence or abuse — Yes ○ No ○
47. Muscle, bone or joint injury — Yes ○ No ○
48. Back pain, injury or "back trouble" — Yes ○ No ○
49. Swollen or painful joints — Yes ○ No ○
50. Suffered any pain severe enough to be disabling — Yes ○ No ○
51. Passed blood with or in urine or faeces — Yes ○ No ○
52. Kidney, bladder or urethral disease — Yes ○ No ○
53. Easy fatiguability or day time sleepiness — Yes ○ No ○
54. Investigations for abnormal glucose tolerance. high blood sugar or diabetes — Yes ○ No ○
55. Medical certificate for absence of 7 or more days from work or school — Yes ○ No ○
56. Rejection or premium loading for life or health insurance — Yes ○ No ○
57. Rejection or retirement from employment on medical grounds — Yes ○ No ○
58. Admission to hospital, psychiatric or in patient facility — Yes ○ No ○
59. Taken any type of medicine or alternative medicine for more than 2 weeks — Yes ○ No ○
60. Had a positive laboratory test for HIV infection — Yes ○ No ○
61. Investigation for any disorder — Yes ○ No ○
62. Any major medical or surgical procedure — Yes ○ No ○
63. Day surgery — Yes ○ No ○
64. Any other illness, disability, debility, infirmity, treatment or surgery — Yes ○ No ○

FEMALES ONLY

65. Any troubling menstrual problems — Yes ○ No ○
66. Other gynaecological problem — Yes ○ No ○
67. Any obstetric problem — Yes ○ No ○
68. Breat lump or other breast problems — Yes ○ No ○
69. **PREGNANCY:** Are you pregnant? — Yes ○ No ○

MALES ONLY

70. Any prostate problem or testicular lump or mass — Yes ○ No ○

PART E - Miscellaneous

Has any medical certificate ever been denied, suspended, or revoked within or outside of Fiji? Yes ◯ No ◯

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? Yes ◯ No ◯

Have you received any Notice under **Civil Aviation Act of the Republic of Fiji** *(suspension, restriction, endorsements, etc)* during the period of the current or last medical certificate? Yes ◯ No ◯

FAMILY HISTORY: Have any members of your family had vascular disease, hypertension, diabetes, heart disease, psychiatric disease or neurological disease?*(Please provide details below)* Yes ◯ No ◯

Relationship ▶	Mother	Father	Siblings	Grandparents	Other
Name of disease & age it was discovered ▶					
Name of disease & age it was discovered ▶					
Name of disease & age it was discovered ▶					
Name of disease & age it was discovered ▶					

SMOKING: Have you ever smoked? Yes ◯ No ◯
If yes, answer the following ▼

In total, how many years have you smoked for? _____

Average quanitity smoked? _____ *(packs/week)*

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

ALCOHOL / KAVA: Do you drink alcohol / kava? Yes ◯ No ◯
If yes, how much do you drink per week? (be specific) ▼

Beer *(cans/bottles)*	Wine *(glasses)*	Spirits *(measures)*	Kava *(bowls)*	Total Units *(weekly)*

I usually drink: in weekends ◯ most days ◯ on days off ◯

Have you VISITED a health professional within last 3 years? Yes ◯ *if yes, explain below* ▼ No ◯

Date	*GP/Specialist*	*Reason*

Have you taken any MEDICATION in past 3 years for 2 weeks or more? Yes ◯ *if yes, explain below* ▼ No ◯

Medication Name	*Dosage*	*Purpose*	*Date started*	*Date finished*

EXERCISES - Do you exercise regularly? Yes ◯ No ◯

Do you undertake any exercise for more than 3 times a week? Yes ◯ *if yes, explain below* ▼ No ◯

List the type of exercises.

If you answered "Yes" to any of the questions above part D to part E, please provide all details of each instance - use extra pages or attach any documents as required.

PART F - Consent & Acknowledgement

Applicant's Name: Licence Number:

I consent to the disclosure of the Chief Executive and, or his/her delegate, of any medical information relation to me, which is held by a registered medical practitioner, hospital or other organization. I consent to the disclosure to the Chief Executive, of information about convictions for alcohol or substance abuse from the Land Transport Authority or any other organisations.

I hereby authorise the Chief Executive to use information obtained concerning me for any purpose authorised by law. I authorise such information to be disclosed by the Chief Executive to any person who requires such information to carry out any function authorised by law. I understand that the Chief Executive may provide relevant medical information to other international jurisdictions for the purpose of aviation medical certification.

I acknowledge and understand the following:

That I have obligations under the Civil Aviation Act of the Republic of Fiji, 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 Chief Executive 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. 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, and is subject, in the case of an individual, to imprisonment for a term not exceeding 12 months or to a fine not exceeding $10,000, and
4. the failure to notify Chief Executive of any change in medical condition or the existence of a previously undetected medical condition constitutes an offence under the Civil Aviation Act, and is subject, in the case of an individual, to imprisonment for a term not exceeding 12 months or to a fine not exceeding $5,000.

I have read this application form, familiarised myself with it and understand its contents, including the consent and acknowledgement in Part F. 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.

Witnessed by (DAME): Date:

B. Medial Examination Report (MER)

Applicant Surname: | Licence Number:

Comments and follow-up on issues raised in the Application for Medical Certificate or history taking:

History:

Medication:

CVD Risk Assessment

Height (no shoes)	cm
Weight	kg
BMI	
○ < 18.5 underweight ○ 18.5 - 24.9 normal weight ○ 25.0 - 29.9 overweight ○ 30.0 - 34.9 class I obesity ○ > 35.0 class II obesity ○ > 40.0 class III obesity	
Blood Pressure	/ mmHg
Pulse	per min
Total Cholestrol	mmol/L
HDL	mmol/L
LDL	mmol/L
Triglycerides	mmol/L
Total Chol/HDL ratio	
Glucose (if required)	mmol/L

Please detail risk factor(s) in applicable risk group for:

Very high risk (Risk > 20%) and **Elevated single risk groups** (Risk > 15%)

OR High Risk Groups (CVD risk as per calculation PLUS additional 5% for any or all of the special factors ticked below):

- **FH premature IHD** ☐
- **Ethnicity** ☐
- **DM with Microalbumin** ☐
- **Type 2 DM > 10 years** ☐
- **Type 2 DM with HbA1c > 8%** ☐
- **Metabolic Syndrome** ☐

Calculated 5 year Risk:
Click here for **CVD Risk Chart**
%

NB: Fresh lipids and glucose tests not required at every examination. Check GD.

Alcohol & Drug Test:

EYES	Uncorrected			Corrected		
Visual acuity	Right	Left	Both	Right	Left	Both
DISTANCE VISUAL ACUITY (6m) Std: Classes 1,3 = 6/9 Classes 2 = 6/12	**6/** 5	**6/** 5	**6/** 5	**6/** 5	**6/** 5	**6/** 5
INTERMEDIATE VISUAL ACUITY (100cm) - Std: N14	**N:** N:24	**N:** N:24	**N:** N:24	**N:** N:24	**N:** N:24	**N:** N:24
NEAR VISUAL ACUITY (33cm) - Std: N5	**N:** N:24	**N:** N:24	**N:** N:24	**N:** N:24	**N:** N:24	**N:** N:24

TYPE OF CORRECTION USED: Write M for main or S for stand-by correction (below symbol)

None ☐ ○ | Bifocal ⊖ ○ | Trifocal ⊜ ○ | Look-over ◡ ○ | Progressive focus ▱ ○ | Contacts ○ ○ | Distance Specs ▭ ○

Are the following ALL normal: Lids; Pupils; Lens; Media; Fundi; Visual Fields by confrontation; Eye movements and Cover tests? *(if NO, elaborate)* Yes ○ No ○

(Initial only and as per GD). Standard ISHIHARA 24-plate book, are first 17 plates read with only ONE or fewer errors? Yes ○ No ○
Record errors below with an "x"

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Applicant's Name: _____ Licence Number: _____

Are the following abnormal, with unusual features? Please ✓:	YES	NO	NOTES: Describe below every abnormality in detail. Use and attach continuation sheets if necessary.
ENT (inc Eust tube, nasal air entry)	○	○	
Speech satisfactory	○	○	
Conversational Voice Test at 2m	○	○	
Audiogram Normal (if required)	○	○	
Heart (size, rhythm, sounds)	○	○	
Vascular system	○	○	
Lungs & Chest (if a condition, proceed with spirometry)	○	○	
Abdomen and viscera (including hernia)	○	○	
Lymphatic system - spleen, lymph nodes	○	○	
Endocrine system	○	○	
Genito-urinary system	○	○	
Skin (indicate identifying marks, scars, tattoos)	○	○	
Locomotor system	○	○	
Neurological examination (reflexes, equilibrium senses, etc)	○	○	
Psychiatric examination	○	○	
Urinalysis - Glucose	○	○	
Urinalysis - Protein	○	○	

Peak flow reading _____

Spirometry *(if indicated)*	Predicted	Recorded
FVC (l)		
FEV1 (l)		
FEV1/FVC(%)		
PEFR (l/min)		

Routine Test Dates:

Last Lipids: ☐☐ ☐☐ ☐☐☐☐

ECG: ☐☐ ☐☐ ☐☐☐☐

Chest X-Ray: ☐☐ ☐☐ ☐☐☐☐

Audiogram: ☐☐ ☐☐ ☐☐☐☐

Specialist Eye: ☐☐ ☐☐ ☐☐☐☐

Do you know the applicant?

Yes ○ No ○

If not, indicate below the type & number of ID used:

☐ Passport/Airport Security

☐ Driving Licence

☐ Others

ID NUMBER

Any other relevant reports, findings, concerns or comments:

DAME STAMP

Print Examiner's Name and Address

Medical Examiner's Declaration:

I hereby certify that I personally identified and examined the applicant name on this medical report and that this report with any attached notes embodies my examination completely and correctly.

ME Signature *Date* ☐☐ ☐☐ ☐☐☐☐

C. Medical Assessment Report (MAR)

Applicant's Name:		Licence Number:	

Report Dates:	GME:	Audio:	ECG:	Lipids:
Documents seen	Pilots License: ☐	Previous Meical Certificate: ☐	Previous MAR: ☐	Others: ☐

Advisory for Next Assessment (recommendations **only**)	**Periodicity**	**Duration**	**Next Due**

Duration of Certificate and Restrictions

	CLASS 1 - Single pilot air ops carrying passengers	**CLASS 1**	**CLASS 2**	**CLASS 3**	**CLASS 4**
Expiry Date					
Restrictions/ Endorsements					
Assessment	☐ **Eligible** ☐ **Ineligible** ☐ **Deferred**	☐ **Eligible** ☐ **Ineligible** ☐ **Deferred**	☐ **Eligible** ☐ **Ineligible** ☐ **Deferred**	☐ **Eligible** ☐ **Ineligible** ☐ **Deferred**	☐ **Eligible** ☐ **Ineligible** ☐ **Deferred**

Additional Information: ☐ **Certified under S 27 B(1)** ☐ **Certified under S 27 B(2) (ie via AMC process)**

SPECIAL EXAMINATION CHECKLIST - Form **MD101**

SPECIAL EXAMINATION	**INDICATE IF DONE IN THIS MEDICAL**		**NEXT DUE (Indicate Date)**
1. ECG	**Yes** ◯	**No** ◯	
2. Audiogram	**Yes** ◯	**No** ◯	
3. Lipids / Sugar	**Yes** ◯	**No** ◯	
4. Hb1Ac	**Yes** ◯	**No** ◯	
5. Renal Function	**Yes** ◯	**No** ◯	
6. Liver Function	**Yes** ◯	**No** ◯	
7. Treadmill	**Yes** ◯	**No** ◯	
8. X-Ray	**Yes** ◯	**No** ◯	
9. Ophthalmology	**Yes** ◯	**No** ◯	
10. Echocardiography	**Yes** ◯	**No** ◯	
11. Spirometry / Peak Flow Meter	**Yes** ◯	**No** ◯	
12.	**Yes** ◯	**No** ◯	
13.	**Yes** ◯	**No** ◯	

Signature of DAME:

DAME Name/Practice Stamp

DAME STAMP

Signature of the Applicant:

Date completed ☐☐ ☐☐ ☐☐☐☐

Total number of pages supplied: ☐☐