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Beirut - Lebanon

☎ 03-288620

APPLICATION FOR AIRMAN MEDICAL CERTIFICATE

Personnel Licensing Division (I. C. A. O.)

Annex I.

Name of Applicant .... Date of Birth ....
Last First Middle Day Month Year

Class of Medical Certificate applied for .... Nationality ....

Address or Phone .... Single ☐ Married ☐ .... Children
number of

Employer .... Color of Eyes .... Color of Hair ....

Flying time : Total .... Hours Last six months .... Hours

Length of time in present occupation .... Primary Type of flying ☐ Business ☐ Pleasure

I. MEDICAL HISTORY

Previous Medical History : Have you ever had Pneumonia, Pleurisy, Tuberculosis, (Pulmonary or else), Heart Trouble, Asthma, Hayfever, Mastoiditis, Sinusitis, Repeated Tonsillitis, Arthritis, Gastric or duodenal ulcer, Jaundice, Hernia, Diabetes, High or low blood pressure, Kidney Stones, Blood in urine, Syphilis, Malaria, Severe wounds, Fractures, Low back pain, Mental disease, Epilepsy, Nervous breakdowns, Attempted Suicide, Repeated episods of alcoholism, Drug addiction, Surgical operations if any, Loss of Consciousness, Eye trouble, Ear trouble, Motion sickness, Admission to hospital, Identification marks on body, (Underline item concerned. Give details) ....

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....

If no change since last report, state so : ....

Family History : Father ☐ Alive ☐ Died .... Mother ☐ Alive ☐ Died ....
age at and cause of death age at and cause of death

Is there any history in family of Mental disease, Diabetes, Myopia, Tuberculosis, of other family disease ....

....

Date of Last Medical Examination I. C. A. O. : .... Result ☐ Fit ☐ Unfit
If none state so

Interval History : Any disease, disability, accident, or surgical operation since last medical examination ....

....

Has an airman medical certificate ever been denied, suspended or revoked ? ☐ No ☐ Yes Date ....

Have you as a pilot ever had an aircraft accident ? ☐ No ☐ Yes Date ....

Currently use any medication (including eye drops) ☐ No ☐ Yes ....
Type and Purpose

II. MEDICAL DECLARATION

I hereby declare that all statements and answers made by me in this examination form are complete and true to the best of my knowledge. I give my consent to the examining medical officer to communicate with any physician which has attended me

Date ....
Day Month Year

....
Applicant's signature

III. PHYSICAL EXAMINATION

MEASUREMENTS.

1. Height	cms.	2. Weight	klgs.	3. Temp.	°C
4. B.P. sitting		reclining	standing		mmHg.
5. Pulse. sitting	reclining	after exercise	2 minutes after exercise		
6. Distant Vision.	R.E.	corrected to	L.E.	corrected to	
7. Near Vision. FAA types	R.E.	corrected to	L.E.	corrected to	
8. Phorias. Eso	Exo	R.H.	L.H.	Diopters at 5 meters	
9. Depth perception	Verhoeff		Corrected to		
10. Dynamometric strength.	Right hand	KLG.	Left hand		KLG.
11. Hearing WVR.	Feet	WVL.	Feet. CVR.	Feet. CVL.	Feet

12. Audiometry (When required) — Hearing loss in decibels

Frequency	250	500	1000	2000	3000	4000	8000
Right Ear							
Left Ear							

No more than 25 decibels loss in the 500 - 1000 - 2000

No more than 40 decibels loss in the 3000 - 4000 - 8000

CLINICAL EVALUATION :

N.	Ab.		N.	Ab.	
		13. General appearance			28. Respiratory system, Breasts
		14. Mental state. Psychiatric			29. Cardio-vascular system
		15. Skin (Body marks, scars, Tattoos)			30. Abdomen, Hernia, viscera
		16. Lymphatic and skeletal system			31. Genito-urinary system
		17. Eyes and ocular movements, general			32. Urinalysis. Sugar & albumin
		18. Intraocular tension - tactil - tonometric			33. Anus, rectum, hemorroids
		19. Pupils. Equality and reaction			34. Spine, other musculoskeletal
		20. Field of vision			35. Upper extremities
		21. Ophtalmoscopy			36. Lower extremities
		22. Color vision. Ishihara tests, AOC			37. Neurologic. Reflexes
		23. Ears and drums, general			38. Neurologic. Sensibility
		24. Nose sinuses and throat			39. Self balancing tests
		25. Mouth and teeth			40. Coordination
		26. Speech			41. ECG Date
		27. Face, neck, head, and scalp			42. Chest X Ray Date

Describe every abnormality in detail (enter pertinent item number before each comment) :

Dental

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

/ Missing
O Decay

REMARKS AND RECOMMENDATIONS

CONCLUSION :

I hereby certify that I personally examined to day

and declare that I found him/her for flying duties as

Limitations

Date of examination

Valid for Months

G F BECHARA M.D.

FORM G.F.B. 79