Department:	**Aviation Medicine**	Form Number: CA 67-2(a)	
Telephone number:	0860 267 435	*Fax Number:*	**011-545-1459**
Physical address	**12 Byls Bridge Boulevard, Building No 2, Byls Bridge Office Park Centurion**		
Postal address:	**Private Bag X73, Halfway House 1685**	*Website:* **www.caa.co.za**	

AVIATION MEDICAL REPORT

POPIA CONSENT AGREEMENT

In accordance with the provisions of the Protection of Personal Information Act No. 4 of 2013 ("POPIA"), all personal information must be processed lawfully and in a manner that does not infringe upon the data subject's right to privacy.

By completing this form in accordance with the Civil Aviation Act No. 13 of 2009 , you consent to the collection, processing, and, where necessary, the disclosure of the personal information provided herein for purposes strictly related to regulatory, administrative, operational, and compliance requirements .This may include, but is not limited to, processing the information for approvals, certification, communication, publication, or any related function reasonably required to fulfil the purpose for which the information was submitted.
Such information will only be shared with authorised third parties, including regulatory bodies such as the Department of Transport, service providers, consultants, or other relevant stakeholders, solely to the extent necessary to discharge the aforementioned obligations.
The South African Civil Aviation Authority ("SACAA") recognises the importance of protecting personal information and undertakes to process and/or publish such information with the highest level of care and in full compliance with the safeguards and obligations imposed by POPIA. (For more information on how the SACAA processes your personal information, kindly refer to our Privacy policy on the SACAA website (link: https://www.caa.co.za/paia-and-privacy/).

PERSONAL INFORMATION

1. Surname		First name(s)	
2. Postal address			
		Postal code	
3. Telephone numbers	During office hours	Cell No.	E-mail
4. Date of birth (dd/mm/yyyy)		5. Nationality	
6.Identity/Passport No.		7. Gender	
8.Occupation and employer		9. Medical Class applied for	
10.Licence Number		11. Licence Type	12.Type of flying Intended: Single-Crew ☐ Multi-crew ☐

Flight time (hours)			**Type of flying intended**			**Previous medical examination**	
Last 6 months	Last 12 months	Total	Recreation	Business	Career	Doctor	Date

13. Have you ever had an aviation Medical Assessment denied, suspended or revoked by any licence authority? If yes Discussed with Medical Examiner.
Yes ☐ **No** ☐ **Date:** **Place:**

Details:

14. Any aircraft /vehicle accident or reported incident since last medical?
Yes ☐ **No** ☐ **Date:** **Place:**

Details:

ID Number/Passport No.		Date	

15. Do you drink alcohol? **Yes** ☐ **No** ☐ If yes, state average weekly intake in units:	16. Do you smoke tobacco products? **Never** ☐ **Previously** ☐ **Currently** ☐ Date stopped: State type, amount and number of years:

17 Do you currently use any medication, including non-prescribed medication? *Please attach additional pages if space is insufficient.*

Yes ☐ **No** ☐

If yes, state the name of medication, date commenced, daily or weekly dose, and diagnosis

14. Any limitations on licence / Restrictions?

Yes ☐ **No** ☐

Details:

MEDICAL HISTORY

Do you have, or have you ever had, any of the following? Yes or No must be ticked after each question.

	Y	N		Y	N
1. Eye disorders/eye surgery			19. Psychological / psychiatric trouble of any sort		
2. Spectacles and/or contact lenses ever worn			20. Alcohol/drug/substance abuse		
3. Spectacles/contact lens prescriptions/change since last medical exam			21. Attempted suicide		
4. Hay fever, other allergy			22. Motion sickness requiring medication		
5. Asthma, lung disease			23. Anaemia/Sickle cell trait/other blood disorders		
6. Heart or vascular disease			24. Malaria or other tropical disease		
7.High or low blood pressure			25. A positive HIV test		
8.Kidney stone or blood in urine			26. Sexually transmitted disease		
9. Diabetes, hormone disorder			27. Bleeding from the rectum		
10. Stomach, liver or intestinal trouble			28. Any other illness or injury		
11.Deafness, ear disease			29. Visit to medical practitioner since last medical examination		
12. Admitted to hospital			30. Refusal of life insurance		
13.Nose or throat disease or speech disorder			31. Refusal of issue or revocation of aviation licence		
14.Head injury or concussion			32. Medical rejection from or for military service		
15. Frequent or severe headaches			33. Award of pension or compensation for injury or illness		
16. Dizziness or fainting spells			34. Gynaecological disorder (including menstrual / pregnancy)		
17. Unconsciousness (for any reason)			35.Prostate Problems		
18.Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.			36.Malignant tumour or cancer		

FAMILY HISTORY OF:

	Y	N		Y	N
37. Heart disease			42. Diabetes		
38. High blood pressure			43. Tuberculosis		
39. High cholesterol level			44. Allergy/asthma/eczema		
40.Epilepsy			45. Inherited disorders		
41.Mental illness			46. Glaucoma		

REMARKS

Comment in full on all items marked YES below. Please attach additional pages if space is insufficient.

ID Number/Passport No.		Date	

Comment in full on all items marked YES below. Please attach additional pages if space is insufficient

NOTICE

Any person who makes, either orally or in writing, a false or misleading statement in or in connection with any application for a licence, certificate or rating issued under these regulations or any return furnished in accordance with any requirement of these regulations, shall be guilty of an offence. (Civil Aviation Regulations (CAR), Part 185.001.1(1)(di-dii)

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 Authority. **Note**: Medical Confidentiality will be respected all times

SIGNATURE OF APPLICANT	**NAME IN BLOCK LETTERS**	**DATE**
	DR BJORN BUCHNER	
SIGNATURE OF AME (AS WITNESS)	**NAME IN BLOCK LETTERS**	**DATE**