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APPLICATION FOR AIRMAN MEDICAL CERTIFICATE OR AIRMAN MEDICAL AND STUDENT PILOT CERTIFICATE

GPO U.S. GOVERNMENT PRINTING OFFICE 2006-552-757

UNITED STATES OF AMERICA
Department of Transportation
Federal Aviation Administration

FF-

MEDICAL CERTIFICATE _____ CLASS AND STUDENT PILOT CERTIFICATE

This certifies that ***(Full name and address):***

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination	Examiner's Designation No.

Examiner

Signature

Typed Name

AIRMAN'S SIGNATURE

FAA Form 8420-2 (3-99) Supersedes Previous Edition

INSTRUCTIONS TO THE AVIATION MEDICAL EXAMINER
GENERAL INSTRUCTIONS FOR ISSUANCE OF ANY MEDICAL CERTIFICATE

Remove this page of instructions and attached certificate as well as the next page of instructions and attached certificate before giving the applicant any part of this form.

INSTRUCTIONS FOR ISSUANCE OF THIS (Medical-Student Pilot) CERTIFICATE

1. Applicant must (a) be at least 16 years of age; (b) be able to read, speak, write, and understand the English language; and (c) qualify at least for a third-class medical certificate.

2. Destroy these instructions and the following page's Medical Certificate and instructions which are printed on white paper.

3. Give the applicant the instructions for completion of the medical history form and the history forms. Have the applicant complete the history form in triplicate.

4. When the application part is completed, destroy its instructions, remove the AME Work Copy (middle sheet in set), and record your medical findings and actions on the AME Work Copy. Type your findings and actions on the FAA/Original Copy. Give the Applicant Copy to the applicant.

5. If the applicant qualifies for a certificate: (a) reassemble the FAA/Original Copy and the AME Work Copy in their original order; (b) superimpose the Medical-Student Pilot Certificate (yellow) on the FAA/Original Copy, upper left area; (c) complete the certificate by typewriter; (d) sign the certificate in ink (both the AME and applicant must sign); and (e) issue the signed certificate to the airman.

6. AME's are required to use the electronic transmission capability of the Aeromedical Certification System (AMCS) and must maintain the FAA/Original Copy in their files or, if directed, forward it to the FAA in Oklahoma (see address below). If the FAA/Original Copy is forwarded to the FAA, the AME Work Copy must be retained as the file copy.

7. BE SURE TO COMPLETE AND SIGN ITEM 64 ON THE FAA/ORIGINAL COPY.

Passenger-Carrying Prohibited

STUDENT PILOT CERTIFICATE

CERTIFICATED INSTRUCTOR'S ENDORSEMENT FOR STUDENT PILOTS

I certify that the holder of this certificate has met the requirements of the regulations and is competent for the following:

A. To Solo The Following Aircraft

DATE	MAKE AND MODEL OF AIRCRAFT	INSTRUCTOR'S SIGNATURE	INSTRUCTOR'S CERT. No.	Exp. Date

B. To Make Solo Cross-Country Flights

Aircraft Category
Airplane
Glider
Rotorcraft

CONDITIONS OF ISSUE: This certificate shall be in the personal possession of the airman at all times while exercising the privileges of his or her airman certificate. The issuance of a medical certificate by an Aviation Medical Examiner may be reversed by the FAA within 60 days. Section 61.19 of Title 14 of the Code of Federal Regulations (14 CFR part 61) sets forth the duration of a student pilot certificate. Unless otherwise limited, the duration of a medical certificate is set forth in § 61.23. The holder of this certificate is governed by the provisions of § 61.53 relating to medical deficiency (14 CFR part 61).

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UNITED STATES OF AMERICA
Department of Transportation
Federal Aviation Administration

MEDICAL CERTIFICATE _____ CLASS

This certifies that *(Full name and address):*

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination	Examiner's Designation No.

Examiner

Signature

Typed Name

AIRMAN'S SIGNATURE

FAA Form 8500-9 (3-99) Supersedes Previous Edition

INSTRUCTIONS FOR ISSUANCE OF THIS MEDICAL CERTIFICATE

1. This certificate is for issuance to applicants other than those applying for a Medical-Student Pilot Certificate.

2. Destroy these instructions and the attached Medical-Student Pilot Certificate and its instructions which are printed on yellow paper.

3. Give the applicant the instructions for completion of the medical history form and the history forms. Have the applicant complete the history form in triplicate.

4. When the application part is completed, destroy its instructions, remove the AME Work Copy (middle sheet in set), and record your medical findings and actions on the AME Work Copy. Type your findings and actions on the FAA/Original Copy. Give the Applicant Copy to the applicant.

5. If the applicant qualifies for a certificate: (a) reassemble the FAA/Original Copy and the AME Work Copy in their original order; (b) superimpose the Medical Certificate (white) on the FAA/Original Copy, upper left area; (c) complete the certificate by typewriter; (d) sign the certificate in ink (both the AME and applicant must sign); and (e) issue the signed certificate to the airman.

6. AME's are required to use the electronic transmission capability of the Aeromedical Certification System (AMCS) and must maintain the FAA/Original Copy in their files or, if directed, forward it to the FAA in Oklahoma (see address below). If the FAA/Original Copy is forwarded to the FAA, the AME Work Copy must be retained as the file copy.

7. BE SURE TO COMPLETE AND SIGN ITEM 64 ON THE FAA/ORIGINAL COPY.

CONDITIONS OF ISSUE

The holder of this certificate must:

- Have it in his or her personal possesion at all times while exercising privileges of an airman certificate. (14CFR § 61.3)
- Understand that the issuance of a medical certificate by an Aviation Medical Examiner may be reversed by the FAA within 60 days. (14CFR § 67.407)
- Comply with validity standards specified for first-, second-, and third-class medical certificates. (14CFR § 61.23)
- Comply with any statement of functional, operational, and/or time limitation issued as a condition of certification. (14CFR § 67.401) (Note: A letter of authorization (or SODA) describing any such limitations must be kept with this certificate at all times while exercising the privileges of an airman certificate.)
- Comply with the standards relating to prohibitions on operation during medical deficiency. (14CFR §§ 61.53, 63.19, and 65.49)

For International Operations Only: Some holders may be affected by certain international medical standards. Consult the U.S. Areronautical Information Publication for U.S. differences with ICAO Annex 1 medical standards.

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U.S. Department
of Transportation
**Federal Aviation
Administration**

INFORMATION FOR APPLICANT

Application For Airman Medical Certificate or Airman Medical and Student Pilot Certificate

Privacy Act Statement

The information on the attached FAA Form 8500-8, Application For Airman Medical Certificate or Airman Medical and Student Pilot Certificate, is solicited under the authority of Title 49, United States Code (U.S.C.) (Transportation) sections 109(9), 40113(a), 44701-44703, and 44709 (1994) formerly codified in the Federal Aviation Act of 1958, as amended, and Title 14, Code of Federal Regulations (CFR), part 67, Medical Standards and Certification.

Except for your Social Security Number (SSN), submission of this information is mandatory. Incomplete submission will result in delay of further consideration or denial of your application for a medical certificate or medical and student pilot certificate. Other than your SSN, the purpose of the information is to determine whether you meet Federal Aviation Administration (FAA) medical requirements to hold a medical certificate or medical and student pilot certificate. The information will also be used to provide data for the FAA's automated medical certification system to depict airman population patterns and to update certification procedures and medical standards. For air traffic control specialists (ATCS) employed by the Federal Government, the information requested will be used as a basis for determining medical eligibility for initial and continuing employment. The information becomes part of the FAA Privacy Act system of records, DOT/FAA-847, General Air Transportation Records on Individuals. These records and information in these records may be used (a) to provide basic airman certification and qualification information to the public upon request; (b) to disclose information to the National Transportation Safety Board (NTSB) in connection with its investigation responsibilities; (c) to provide information about airmen to Federal, state, and local law enforcement agencies when engaged in the investigation and apprehension of drug law violators; (d) to provide information about enforcement actions arising out of violations of the Federal Aviation Regulations to government agencies, the aviation industry, and the public upon request; (e) to disclose information to another Federal agency, or to a court or an administrative tribunal, when the Government or one of its agencies is a party to a judicial proceeding before the court or involved in administrative proceedings before the tribunal; and (f) to disclose information to other Federal agencies for verification of the accuracy or completeness of the information and; (g) to comply with the Prefatory Statement of General Routine Uses for the Department of Transportation.

Submission of your SSN is not required by law and is voluntary. Refusal to furnish your SSN will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited to assist in performing the agency's functions under 49 U.S.C. (Transportation). If supplied, it will be used by the FAA to associate all information in agency files relating to you. If you refuse to supply your SSN, a substitute number or other identifier will be assigned, as required.

The written consent authorization of this form under No. 20, Applicant's Declaration, permits the FAA to request information, if any, pertaining to your driving record from the National Driver Register (NDR). The FAA will then match such NDR information with the information you provide on the medical history part of the form. Since the NDR identifies only probable matches, the FAA will verify the NDR information it receives with the state of record. You have the right to request an NDR file check to determine if it contains any information and, if so, the accuracy of such information. Notarized requests may be sent to: DOT/NHTSA/NTS-32, 400 7th Street, S.W., Washington, DC 20590-0001, and must contain your complete name and date of birth. Other information about height, weight, and eye color will ensure correct positive identification.

Paperwork Reduction Act Statement:
The information collected on this form is necessary to ensure applicants meet the minimum requirements as set forth under the authority of 49 U.S.C. (Transportation). This information will be used to determine applicant eligibility for a medical certificate, medical and student pilot certificate, or ATCS eligibility for employment. When all requirements have been met, an appropriate medical certificate, medical and student pilot certificate, or medical clearance will be issued. It is estimated that it will take each applicant 2 hours to complete this form and provide all the information called for (includes providing medical history information and physical examination). The information is required to obtain a certificate and is confidential. The information will become part of the Privacy Act system of records DOT/FAA 847, General Air Transportation Records on Individuals. Note that an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this collection of information is 2120-0034.

Tear off this cover sheet before submitting this form.

Instructions for Completion of the Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate, FAA Form 8500-8

Applicant must fill in completely numbers 1 through 20 of the application using a ballpoint pen. Exert sufficient pressure to make legible copies. The following numbered instructions apply to the numbered headings on the application form that follows this page.

NOTICE – Intentional falsification may result in federal criminal prosecution. Intentional falsification may also result in suspension or revocation of all airman, ground instructor, and medical certificates and ratings held by you, as well as denial of this application for medical certification.

1. APPLICATION FOR – Check the appropriate box.

2. CLASS OF AIRMAN MEDICAL CERTIFICATE APPLIED FOR – Check the appropriate box for the class of airman medical certificate for which you are making application.

3. FULL NAME – If your name has changed for any reason, list current name on the application and list any former name(s) in the EXPLANATIONS box of number 18 on the application.

4. SOCIAL SECURITY NUMBER – The social security number is optional; however, its use as a unique identifier does eliminate mistakes.

5. ADDRESS – Give permanent mailing address and country. Include your complete nine digit ZIP code if known. Provide your current area code and telephone number.

6. DATE OF BIRTH – Specify month (MM), day (DD), and year (YYYY) in numerals; e.g., 01/31/1950. Indicate citizenship; e.g., U.S.A.

7. COLOR OF HAIR – Specify as brown, black, blond, gray, or red. If bald, so state. Do not abbreviate.

8. COLOR OF EYES – Specify actual eye color as brown, black, blue, hazel, gray, or green. Do not abbreviate.

9. SEX – Indicate male or female.

10. TYPE OF AIRMAN CERTIFICATE(S) YOU HOLD – Check applicable block(s). If "Other" is checked, provide name of certificate.

11. OCCUPATION – Indicate major employment. "Pilot" will be used only for those gaining their livelihood by flying.

12. EMPLOYER – Provide your employer's full name. If self-employed, so state.

13. HAS YOUR FAA AIRMAN MEDICAL CERTIFICATE EVER BEEN DENIED, SUSPENDED, OR REVOKED – If "yes" is checked, give month and year of action in numerals.

14. TOTAL PILOT TIME TO DATE – Give total number of civilian flight hours. Indicate whether logged or estimated. Abbreviate as Log. or Est.

15. TOTAL PILOT TIME PAST 6 MONTHS – Give number of civilian flight hours in the 6-month period immediately preceding date of this application. Indicate whether logged or estimated. Abbreviate as Log. or Est.

16. MONTH AND YEAR OF LAST FAA MEDICAL EXAMINATION – Give month and year in numerals. If none, so state.

17.a. DO YOU CURRENTLY USE ANY MEDICATION (Prescription or Nonprescription) – Check "yes" or "no." If "yes" is checked, give name of medication(s) and indicate if the medication was listed in a previous FAA medical examination. See **NOTE** below.

17.b. Indicate whether you use near vision contact lens(es) while flying.

18. MEDICAL HISTORY – Each item under this heading must be checked either "yes" or "no." You must answer "yes" for every condition you have ever been diagnosed with, had, or presently have and describe the condition and approximate date in the EXPLANATIONS block.

If information has been reported on a previous application for airman medical certificate and there has been no change in your condition, you may note "PREVIOUSLY REPORTED, NO CHANGE" in the EXPLANATIONS box, but you must still check "yes" to the condition. Do not report occasional common illnesses such as colds or sore throats.

"Substance dependence" is defined by any of the following: increased tolerance; withdrawal symptoms; impaired control of use; or continued use despite damage to health or impairment of social, personal, or occupational functioning. "Substance abuse" includes the following: use of an illegal substance; use of a substance or substances in situations in which such use is physically hazardous; or misuse of a substance when such misuse has impaired health or social or occupational functioning. "Substances" include alcohol, PCP, marijuana, cocaine, amphetamines, barbiturates, opiates, and other psychoactive chemicals.

Arrest, Conviction and/or Administrative Action History - Letter (v) of this subheading asks if you have ever been: (1) arrested and/or convicted (which may include paying a fine, or forfeiting bond or collateral) of an offense involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) arrested, convicted or subject to an administrative action by a state or other jurisdiction for an offense for which your license was denied, suspended, cancelled, or revoked or which resulted in attendance at an educational or rehabilitation program. Individual traffic convictions are not required to be reported if they did not involve: alcohol or a drug; suspension, revocation, cancellation, or denial of driving privileges; or attendance at an educational or rehabilitation program. If "yes" is checked, a description of the conviction(s) and/or administrative action(s) must be given in the EXPLANATIONS box. The description must include: (1) the alcohol or drug offense for which you were convicted or the type of administrative action involved (e.g., attendance at an alcohol treatment program in lieu of conviction; license denial, suspension, cancellation, or revocation for refusal to be tested; educational safe driving program for multiple speeding convictions; etc.); (2) the name of the state or other jurisdiction involved; and (3) the date of the conviction and/or administrative action. The FAA may check state motor vehicle driving licensing records to verify your responses. Letter (w) of this subheading asks if you have ever had any other (nontraffic) convictions (e.g., assault, battery, public intoxication, robbery, etc.). If so, name the charge for which you were convicted and the date of conviction in the EXPLANATIONS box. See NOTE below.

– List all visits in the last 3 years to a physician, physician assistant, nurse practitioner, psychologist, clinical social worker, or substance abuse specialist for treatment, examination, or medical/mental evaluation. List visits for counseling only if related to a personal substance abuse or psychiatric condition. Give date, name, address, and type of health professional consulted and briefly state reason for consultation. Multiple visits to one health professional for the same condition may be aggregated on one line. Routine dental, eye, and FAA periodic medical examinations and consultations with your employer-sponsored employee assistance program (EAP) may be excluded unless the consultations were for your substance abuse or unless the consultations resulted in referral for psychiatric evaluation or treatment. See **NOTE** below.

20. APPLICANT'S DECLARATION – Two declarations are contained under this heading. The first authorizes the National Driver Register to release adverse driver history information, if any, about the applicant to the FAA. The second certifies the completeness and truthfulness of the applicant's responses on the medical application. The declaration section must be signed and dated by the applicant after the applicant has read it.

NOTE: If more space is required to respond to "yes" answers for numbers 17, 18, or 19, use a plain sheet of paper bearing the information, your signature, and the date signed.

Applicant — Please Tear Off This Sheet After Completing The Application Form.

FAA Form 8500-8 (3-99) Supersedes Previous Edition NSN: 0052-00-670-6002

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4A ☐

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT

Form Approved OMB NO. 2120-0034

Copy of FAA Form 8500-9 (Medical Certificate) or FAA Form 8420-2 (Medical/Student Pilot Certificate) issued.

FF-

MEDICAL CERTIFICATE _____ CLASS AND STUDENT PILOT CERTIFICATE

This certifies that ***(Full name and address):***

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination | Examiner's Designation No.

Examiner

Signature

Typed Name

AIRMAN'S SIGNATURE

1. Application For: ☐ Airman Medical Certificate ☐ Airman Medical and Student Pilot Certificate

2. Class of Medical Certificate Applied For: ☐ 1st ☐ 2nd ☐ 3rd

3. Last Name **First Name** **Middle Name**

4. Social Security Number — —

5. Address Telephone Number ( ) —

Number / Street

City State / Country Zip Code

6. Date of Birth _____ (M M / D D / Y Y Y Y)

Citizenship _____

7. Color of Hair

8. Color of Eyes

9. Sex

10. Type of Airman Certificate(s) You Hold:

☐ None ☐ ATC Specialist ☐ Flight Instructor ☐ Recreational
☐ Airline Transport ☐ Flight Engineer ☐ Private ☐ Other
☐ Commercial ☐ Flight Navigator ☐ Student _____

11. Occupation

12. Employer

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? ☐ **Yes** ☐ **No** If yes, give date _____ (M M / D D / Y Y Y Y)

Total Pilot Time (Civilian Only)
14. To Date **15. Past 6 Months**

16. Date of Last FAA Medical Application _____ (M M / D D / Y Y Y Y) ☐ **No Prior Application**

17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)?
☐ **No** ☐ **Yes** (If yes, below list medication(s) used and check appropriate box).

	Previously Reported Yes	No
	☐	☐
	☐	☐
	☐	☐

(If more space is required, see 17. a. on the instruction sheet).

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying? ☐ **Yes** ☐ **No**

18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. **See Instructions Page**

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a. ☐	☐	Frequent or severe headaches	g. ☐	☐	Heart or vascular trouble	m. ☐	☐	Mental disorders of any sort; depression, anxiety, etc.	r. ☐	☐	Military medical discharge
b. ☐	☐	Dizziness or fainting spell	h. ☐	☐	High or low blood pressure	n. ☐	☐	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.	s. ☐	☐	Medical rejection by military service
c. ☐	☐	Unconsciousness for any reason	i. ☐	☐	Stomach, liver, or intestinal trouble				t. ☐	☐	Rejection for life or health insurance
d. ☐	☐	Eye or vision trouble except glasses	j. ☐	☐	Kidney stone or blood in urine	o. ☐	☐	Alcohol dependence or abuse	u. ☐	☐	Admission to hospital
e. ☐	☐	Hay fever or allergy	k. ☐	☐	Diabetes	p. ☐	☐	Suicide attempt	x. ☐	☐	Other illness, disability, or surgery
f. ☐	☐	Asthma or lung disease	l. ☐	☐	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	q. ☐	☐	Motion sickness requiring medication	y. ☐	☐	Medical disability benefits

Arrest, Conviction, and/or Administrative Action History --- See Instructions Page

Yes	No		Yes	No	
v. ☐	☐	History of (1) any arrest, and/or conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any arrest, and/or conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.	w. ☐	☐	History of nontraffic conviction(s) (misdemeanors or felonies).

Explanations: See Instructions Page

FOR FAA USE

Review Action Codes

19. Visits to Health Professional Within Last 3 Years. ☐ **Yes** (Explain Below) ☐ **No** **See Instructions Page**

Date	Name, Address, and Type of Health Professional Consulted	Reason

— NOTICE —

Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willingly falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Secs. 1001; 3571).

20. Applicant's National Driver Register and Certifying Declarations

I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S Code 401, Note.

NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.

I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.

Signature of Applicant | Date (M M / D D / Y Y Y Y)

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B-4A

NOTE: FAA/Original Copy of the Report of Medical Examination Must be TYPED.

REPORT OF MEDICAL EXAMINATION

21. Height (inches)	**22. Weight** (pounds)	**23. Statement of Demonstrated Ability (SODA)** ☐ YES ☐ NO Defect Noted:	**24. SODA Serial Number**

CHECK EACH ITEM IN APPROPRIATE COLUMN	Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN	Normal	Abnormal
25. Head, face, neck, and scalp			37. Vascular system (Pulse, amplitude and character; arms, legs, others)		
26. Nose			38. Abdomen and viscera (Including hernia)		
27. Sinuses			39. Anus (Not including digital examination)		
28. Mouth and throat			40. Skin		
29. Ears, general (Internal and external canals; Hearing under item 49)			41. G-U system (Not including pelvic examination)		
30. Ear Drums (Perforation)			42. Upper and lower extremities (Strength and range of motion)		
31. Eyes, general (Vision under items 50 to 54)			43. Spine, other musculoskeletal		
32. Ophthalmoscopic			44. Identifying body marks, scars, tattoos (Size & location)		
33. Pupils (Equality and reaction)			45. Lymphatics		
34. Ocular motility (Associated parallel movement, nystagmus)			46. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)		
35. Lungs and chest (Not including breast examination)			47. Psychiatric (Appearance, behavior, mood, communication, and memory)		
36. Heart (Precordial activity, rhythm, sounds, and murmurs)			48. General systemic		

NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

49. Hearing	Record Audiometric Speech Discrimination Score Below		**Right Ear**					**Left Ear**				
Conversational Voice Test at 6 Feet ☐ Pass ☐ Fail		Audiometer Threshold in decibels	500	1000	2000	3000	4000	500	1000	2000	3000	4000

50. Distant Vision	**51.a. Near Vision**	**51.b. Intermediate Vision - 32 Inches**	**52. Color Vision**
Right 20/ Corrected to 20/	Right 20/ Corrected to 20/	Right 20/ Corrected to 20/	☐ Pass
Left 20/ Corrected to 20/	Left 20/ Corrected to 20/	Left 20/ Corrected to 20/	☐ Fail
Both 20/ Corrected to 20/	Both 20/ Corrected to 20/	Both 20/ Corrected to 20/	

53. Field of Vision ☐ Normal ☐ Abnormal	**54. Heterophoria 20'** (in prism diopters)	**Esophoria**	**Exophoria**	**Right Hyperphoria**	**Left Hyperphoria**

55. Blood Pressure Systolic / Diastolic (Sitting, mm of Mercury)	**56. Pulse** (Resting)	**57. Urine Test** (if abnormal, give results) ☐ Normal ☐ Abnormal	Albumin	Sugar	**58. ECG** (Date) M M D D Y Y Y Y
/					

59. Other Tests Given

60. Comments on History and Findings: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.)

FOR FAA USE

Pathology Codes:

Coded By:

Clerical Reject

Significant Medical History ☐ YES ☐ NO **Abnormal Physical Findings** ☐ YES ☐ NO

61. Applicant's Name

62. Has Been Issued — ☐ Medical Certificate ☐ Medical & Student Pilot Certificate
☐ **No Certificate Issued —** Deferred for Further Evaluation
☐ **Has Been Denied —** Letter of Denial Issued (Copy Attached)

63. Disqualifying Defects (List by item number)

64. Medical Examiner's Declaration — I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.

Date of Examination M M D D Y Y Y Y	Aviation Medical Examiner's Name	Aviation Medical Examiner's Signature
	Street Address	
		AME Serial Number
	City State Zip Code	AME Telephone ( )

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5A ☐

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT

Form Approved OMB NO. 2120-0034

Copy of FAA Form 8500-9 (Medical Certificate) or FAA Form 8420-2 (Medical/Student Pilot Certificate) issued.

FF-

MEDICAL CERTIFICATE _____ CLASS AND STUDENT PILOT CERTIFICATE

This certifies that ***(Full name and address):***

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination | Examiner's Designation No.

Examiner Signature

Typed Name

AIRMAN'S SIGNATURE

1. Application For: ☐ Airman Medical Certificate ☐ Airman Medical and Student Pilot Certificate

2. Class of Medical Certificate Applied For: ☐ 1st ☐ 2nd ☐ 3rd

3. Last Name **First Name** **Middle Name**

4. Social Security Number — —

5. Address Telephone Number ( ) —

Number / Street

City State / Country Zip Code

6. Date of Birth _____ (M M / D D / Y Y Y Y)

Citizenship _____

7. Color of Hair **8. Color of Eyes** **9. Sex**

10. Type of Airman Certificate(s) You Hold:

☐ None ☐ ATC Specialist ☐ Flight Instructor ☐ Recreational
☐ Airline Transport ☐ Flight Engineer ☐ Private ☐ Other
☐ Commercial ☐ Flight Navigator ☐ Student _____

11. Occupation **12. Employer**

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? ☐ **Yes** ☐ **No** If yes, give date _____ (M M / D D / Y Y Y Y)

Total Pilot Time (Civilian Only)
14. To Date **15. Past 6 Months**

16. Date of Last FAA Medical Application _____ (M M / D D / Y Y Y Y) ☐ **No Prior Application**

17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)?
☐ **No** ☐ **Yes** (If yes, below list medication(s) used and check appropriate box).

	Previously Reported Yes	No
	☐	☐
	☐	☐
	☐	☐

(If more space is required, see 17. a. on the instruction sheet).

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying? ☐ **Yes** ☐ **No**

18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. **See Instructions Page**

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a. ☐	☐	Frequent or severe headaches	g. ☐	☐	Heart or vascular trouble	m. ☐	☐	Mental disorders of any sort; depression, anxiety, etc.	r. ☐	☐	Military medical discharge
b. ☐	☐	Dizziness or fainting spell	h. ☐	☐	High or low blood pressure	n. ☐	☐	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.	s. ☐	☐	Medical rejection by military service
c. ☐	☐	Unconsciousness for any reason	i. ☐	☐	Stomach, liver, or intestinal trouble				t. ☐	☐	Rejection for life or health insurance
d. ☐	☐	Eye or vision trouble except glasses	j. ☐	☐	Kidney stone or blood in urine	o. ☐	☐	Alcohol dependence or abuse	u. ☐	☐	Admission to hospital
e. ☐	☐	Hay fever or allergy	k. ☐	☐	Diabetes	p. ☐	☐	Suicide attempt	x. ☐	☐	Other illness, disability, or surgery
f. ☐	☐	Asthma or lung disease	l. ☐	☐	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	q. ☐	☐	Motion sickness requiring medication	y. ☐	☐	Medical disability benefits

Arrest, Conviction, and/or Administrative Action History --- See Instructions Page

Yes	No		Yes	No	
v. ☐	☐	History of (1) any arrest, and/or conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any arrest, and/or conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.	w. ☐	☐	History of nontraffic conviction(s) (misdemeanors or felonies).

Explanations: See Instructions Page

FOR FAA USE
Review Action Codes

19. Visits to Health Professional Within Last 3 Years. ☐ **Yes** (Explain Below) ☐ **No** **See Instructions Page**

Date	Name, Address, and Type of Health Professional Consulted	Reason

— NOTICE —

Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willingly falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Secs. 1001; 3571).

20. Applicant's National Driver Register and Certifying Declarations

I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S Code 401, Note.

NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.

I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.

Signature of Applicant | Date (M M / D D / Y Y Y Y)

8610006268

6A ☐

6A ☐

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT

Form Approved OMB NO. 2120-0034

Copy of FAA Form 8500-9 (Medical Certificate) or FAA Form 8420-2 (Medical/Student Pilot Certificate) issued.

FF-

MEDICAL CERTIFICATE _____ CLASS AND STUDENT PILOT CERTIFICATE

This certifies that ***(Full name and address):***

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination | Examiner's Designation No.

Examiner

Signature

Typed Name

AIRMAN'S SIGNATURE

1. Application For: ☐ Airman Medical Certificate ☐ Airman Medical and Student Pilot Certificate

2. Class of Medical Certificate Applied For: ☐ 1st ☐ 2nd ☐ 3rd

3. Last Name **First Name** **Middle Name**

4. Social Security Number — —

5. Address Telephone Number ( ) —

Number / Street

City State / Country Zip Code

6. Date of Birth _____ (M M / D D / Y Y Y Y)

Citizenship _____

7. Color of Hair

8. Color of Eyes

9. Sex

10. Type of Airman Certificate(s) You Hold:

☐ None ☐ ATC Specialist ☐ Flight Instructor ☐ Recreational
☐ Airline Transport ☐ Flight Engineer ☐ Private ☐ Other
☐ Commercial ☐ Flight Navigator ☐ Student _____

11. Occupation

12. Employer

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? ☐ **Yes** ☐ **No** If yes, give date _____ (M M / D D / Y Y Y Y)

Total Pilot Time (Civilian Only)
14. To Date **15. Past 6 Months**

16. Date of Last FAA Medical Application _____ (M M / D D / Y Y Y Y) ☐ **No Prior Application**

17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)?
☐ **No** ☐ **Yes** (If yes, below list medication(s) used and check appropriate box).

	Previously Reported Yes	No
	☐	☐
	☐	☐
	☐	☐

(If more space is required, see 17. a. on the instruction sheet).

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d. ☐	☐	Eye or vision trouble except glasses	j. ☐	☐	Kidney stone or blood in urine	o. ☐	☐	Alcohol dependence or abuse	u. ☐	☐	Admission to hospital
e. ☐	☐	Hay fever or allergy	k. ☐	☐	Diabetes	p. ☐	☐	Suicide attempt	x. ☐	☐	Other illness, disability, or surgery
f. ☐	☐	Asthma or lung disease	l. ☐	☐	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	q. ☐	☐	Motion sickness requiring medication	y. ☐	☐	Medical disability benefits

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Signature of Applicant | Date (M M / D D / Y Y Y Y)