U.S. Department
of Transportation
Federal Aviation
Administration

INFORMATION FOR APPLICANT

OPHTHALMOLOGICAL EVALUATION FOR GLAUCOMA

Privacy Act Statement

Information requested on this form is solicited under the authority of Title 49 of the United States Code (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 of the Code of Federal Regulations (CFR), Part 67, Medical Standards and Certification. Submission of this information is mandatory and incomplete submission will result in delay of consideration of or denial of application for an airman medical certificate.

The purpose of this information is to determine whether an applicant meets Federal Aviation Administration medical requirements to hold an airman medical certificate for further consideration under 14 CFR 11.53 and 67.401. It is also used to depict airman population patterns and to update certification procedures and medical standards. The information collected on this form becomes a part of the Privacy Act System of Records DOT/FAA 847, General Air Transportation Records on individuals, and is provided the protection outlined in the system's description as published in the Federal Register.

Paperwork Reduction Act Statement: Applicants with glaucoma must submit FAA Form 8500-14, Ophthalmological Evaluation for Glaucoma. Information on this form enables FAA medical personnel to evaluate and determine the permissible operational activities of applicants that are commensurate with their medical condition and public safety. Submission of information is mandatory.

The purpose of this information is to determine whether an applicant meets FAA medical requirements to hold an airman medical certificate for further consideration under Title 14 of the Code of Federal Regulations (CFR) 11.53 and 67.401. Any person who is denied a medical certificate by an aviation medical examiner may appeal to the Federal Air Surgeon under 14 CFR 67.409, Denial of medical certificate. This information is also used to depict airman population patterns and to update certification procedures and medical standards.

If you wish to comment on the accuracy of the estimate or make suggestions for reducing this burden, please direct your comments to the FAA at the following address: Federal Aviation Administration; Aeromedical Certification Division, AAM-300; P.O. Box 26080; Oklahoma City, OK 73126-9922. The public reporting burden for collection of information is estimated to average 15 minutes per response. The 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 paperwork burden associated with this form is currently approved under OMB number 2120-0034.Comments concerning the accuracy of this burden and suggestions for reducing the burden should be directed to the FAA at: 800 Independence Ave SW, Washington, DC 20591, Attn: Information Collection Clearance Officer, ABA-20

Tear off this cover sheet before submitting this form

Form Approved OMB No. 2120-0034
01/31/2008

OPHTHALMOLOGICAL EVALUATION FOR GLAUCOMA

U S. DEPARTMENT OF TRANSPORTATION
FEDERAL AVIATION ADMINISTRATION

1. DATE

2A. NAME OF AIRMAN (Last, First, Middle)	**2B. DATE OF BIRTH** (Month, Day, Year)	**2C. SEX** (M or F)

3. ADDRESS OF AIRMAN *(No. Street, City, State, Zip Code)*

4. HISTORY -- Record pertinent history, past and present, concerning general health and visual problems.

5. FAMILY HISTORY OF GLAUCOMA

6. Diagnosis

A. TYPE *(Check One)* ☐ Simple, Wide Angle, Open ☐ Closed Angle, Narrow Angle. Angle Closure

B. DISCOVER -- e.g., routine examination, FAA physical examination, acute symptoms, reduction in visual acuity, etc.

C. CONFIRMATION -- Tonometric readings, gonioscopy visual fields, tonography, or provocative tests. GIVE METHODS, RESULTS AND DATE CONFIRMED

7. SURGERY

A. IF SURGERY HAS BEEN PERFORMED, INDICATE WHICH EYE AND TYPE OF SURGERY.

B. IS SURGERY ANTICIPATED WITHIN 24 MONTHS? ☐ YES, PROBABLE ☐ NO, NOT LIKELY

8. INITIAL RESPONSE TO THERAPY -- Indicate results including strength, frequency and type of medication used at that time.

9. PRESENT TREATMENT -- Indicate exact type, strength, frequency, and name of medication being used.

10. ADEQUACY OF CONTROL

A. DESCRIBE PRIOR CONTROL, INCLUDING SERIAL TONOMETRIC FINDINGS, CHANGES IN VISUAL FIELDS, ETC.

B. MAXIMUM INTRAOCULAR PRESSURES IN RELATIONSHIP TO DAILY MEDICATION *(If known).*

C. INTRACOCULAR PRESSURE

O.D.	O.S.	TEST METHOD USED	TIME SINCE LAST MEDICATION

NOTE -- Pressures should NOT be taken within 2 hours after use of medication unless 10.B. is completed.

11. FIELD OF VISION -- Record physiological and any pathological peripheral or central visual field losses from a perimeter and/or tangent screen using white test object -- ***SUBMIT OR ATTACH CHARTS***

A. DID EXAMINEE WEAR GLASSES OR CONTACT LENSES DURING TEST? (Specify which)	**B. SIZE OF TEST OBJECT USED WITH TANGENT SCREEN**

12. VISUAL ACUITY -- Record *(Use Snellen linear values)*

	TEST METHOD USED	UNCORRECTED			CORRECTED		
A. DISTANT		O. D.	O.S.	O. U.	O. D.	O.S.	O. U.
B. NEAR	TEST METHOD USED	UNCORRECTED			CORRECTED		
		O.D.	O.S.	O.U.	O.D.	O.S.	O.U.
C. INTERMEDIATE (32 INCHES)	TEST METHOD USED	UNCORRECTED			CORRECTED		
		O.D.	O.S.	O.U.	O.D.	O.S.	O.U.

D. IMPORTANT -- If correction is needed and there is inability to correct either eye to 20/20 or better, give reasons.

13. PRESENT CORRECTION

DOES AIRMAN WEAR?	O.D.	O.S.
	SPHERE-CYLINDER AXIS	SPHERE CYLINDER AXIS
☐ GLASSES ☐ CONTACT LENSES		

14. PUPILS -- Statement of relative size and reaction of the pupils to accommodation and light, with special reference to any disease process, healed or active

15. OPTHALMOSCOPIC -- Describe any variations from normal in either eye on funduscopic examinations, with special reference to any disease process, healed or active.

16. SLIT LAMP -- Record results of slit lamp examination of each eye where indicated.

17. FUSION --Estimate fusion ability and state methods used in examination

18A. TYPED NAME AND ADDRESS OF EYE SPECIALIST	**18B. SIGNATURE OF EYE SPECIALIST**