Federal Aviation Administration

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# FAA MedXPress

FEDERAL AVIATION ADMINISTRATION

- home
- logout
- help

Green text: INSTRUCTIONS (will be a bubble)
Red text: NEW for this form
Pink text: additional BUBBLE (typically statutes, include links)
Purple text: NOTE for IT - will not be on form

1. Application For: Airman Medical Certificate  FAA ATCS medical clearance  Other

Select the type of application you want. If Other, please explain in the box provided why you made that choice.

2. Class of Medical Cert.: 1st 2nd 3rd

Select the appropriate class of medical certificate that you want to apply for. See 14CFR§61.23 for the requirements for medical certificates.

3. Last Name:  First Name:  Middle Name:  Suffix:

Former Names:

Enter your legal name in the boxes provided. If your name changed for any reason, list your current name on the application and then list all your former name(s) in the box provided. Separate your former names with a comma or semicolon. See 14CFR§61.25 for the requirements for Change of Name.

4. U.S. Address of Record/Permanent Mailing Address  International Address of Record

If U.S. is selected, these boxes will show:

Street Address:

City:  State:  Zip Code:

Telephone Numbers: Home:  Cell:  Work:

Email address:

If International is selected, these boxes will show:

Street Address:

City or Town Name:  Other Principal Subdivision (Province, State, County, etc.):

Postal Code:  Full Country Name:

Telephone Numbers: Home:  Cell:  Work:

Email Address:

Previous address question will show for both US and International:

Have you recently changed your address? Yes No  See 14CFR§61.60 for the requirements for Change of Address.

Previous Address(es):

In the boxes provided:

- Select either U.S. or International Address and enter your address of record.
- Enter an address where you receive all of your mail and where you would retrieve mail most frequently. (Include your complete zip or postal code.)
- Enter your previous address(es) if the address you provided is a new address. Separate your previous address(es) with a comma or semicolon.
- Enter your home, cell, and work phone numbers.
- Enter your email address.

5. Date of Birth:  Citizenship:

Select month, day, and year (e.g., 01/31/1950). Select citizenship (e.g., USA) from the drop down box.

6. Hair Color:

Select hair color by selecting the appropriate value from the drop down box.

7. Eye Color:

Select eye color by selecting the appropriate value from the drop down box.

8. Sex: Male Female

Select male or female.

Save  Next

9. Type of Airman Certificate(s) You Hold: See Statute § 44703. Airman certificates.

Select the boxes that apply. If you checked "Other Airman Certificate," choose the name of that certificate from the drop down box.

| | | | |
|---|---|---|---|
| ☐ None | ☐ Non-FAA Control Tower Operator [§65.33(d)] | ☐ Flight Instructor | ☐ Recreational |
| ☐ Airline Transport | ☐ Flight Engineer | ☐ Private | ☐ Other Airman Certificate: |
| ☐ Commercial | ☐ Flight Navigator | ☐ Student | |

10. Occupation: If you selected other, please specify your occupation:

Select your primary means of employment from the drop-down menu. Select "Pilot" only if you currently work as a pilot. If you select "Other," specify your occupation in the box provided.

11. Employer:

Enter your employer's full name. Enter "self-employed" if applicable.

12. Has Your FAA Airman Medical Certificate Ever Been Denied, Modified, Suspended, or Revoked? ○ Yes ○ No If yes, give year:

☐ Unknown/Can't Recall

Select "Yes" or "No." If you select yes, enter the year your certificate was denied, modified, suspended, or revoked. Check the box for "Unknown/Can't Recall" if you do not remember the year. See Statute 49 U.S.C. 44709. Amendments, modifications, suspensions, and revocations of certificates.

Total Pilot Flight Time (Civilian only)

13. To Date: Est. ☐ Log. ☐ 14. Past 6 months: Est. ☐ Log. ☐

For 13, enter your total number of flight hours. Check whether you logged or estimated your flight hours.

For 14, enter your total number of flight hours in the 6-month period immediately before the date of this application. Check whether you logged or estimated your flight hours.

15. Date of Last FAA Medical Certificate Examination: No Prior Examination ☐

Enter month, day, and year (e.g., 01/31/2013). If this is your first-ever application, select "No Prior Examination."

Save Next

16. Do You Wear Vision Correction? ○ Yes ○ No

| | | |
|---|---|---|
| a. Glasses | ○ Yes ○ No | If yes, select type: |
| b. Contact Lenses | ○ Yes ○ No | If yes, select type: |
| c. Both Glasses and Contact Lenses | ○ Yes ○ No | If yes, select types above. |
| d. Sunglasses as a sole means of correction | ○ Yes ○ No | |
| e. Do you wear near-vision correction in one eye only? | ○ Yes ○ No | |

1. Select "Yes" or "No."
2. If you selected "Yes:"
   - Check a., b., c., d., and e. either "Yes" or "No."
   - If you selected "Yes" for questions a., b., or c., select the type of glasses and/or contact lenses you use from the drop down menus.
   - If you selected "Yes" for question c., also select "Yes" for questions a. and b.

17. Do You Currently Use, or Have You Used Within the Past 6 Months, Any Prescription Medication, and/or Any Nonprescription Medication on a regular or recurring basis?

○ Yes ○ No

Click here for help on entering medications.

1. Select "Yes" or "No."
2. If you selected "Yes:"
   - Enter the name of your first medication in the "Medication Name" box;
   - Enter the dosage amount in the "Dosage" box;
   - From the "Dosage Unit" box, select a dosage unit for your medication; and
   - From the "Frequency" box, select how often you use the medication.
3. If you previously reported the medication(s) on an FAA medical certificate application:
   - Select the "Previously Reported" box;
   - Click the "Add" button;
   - Select the correct medication name from the "Medication Name" box; and
   - Click the "Add" button again.
4. If an exact match for the medication does not appear, you will see an error message followed by a drop-down box of possible matches.
   - If you see the correct match, select it and click the "Add" button again. If you do not see the correct match, select "Could not Locate Medication" and click the "Add" button again. The medication and its associated dosage information will display below the appropriate column headings as "Medication not listed."
5. Repeat Step 2 for each medication.

Note: Select the "Delete" link that is to the right of each medication to delete medications on your list. MedXPress automatically corrects any medications you misspell.

Medication rollover: Oral, nasal, topical, by injection, etc.
Prescription rollover: Medications specifically prescribed by a physician.
Nonprescription rollover: Over-the-counter medications such as pseudoephedrine, ibuprofen, and aspirin.

**Click the "Add" button to enter each medication prescribed to you. You must enter the Medication Name, but all other fields are optional. You must enter ALL the prescribed medication you take.**

Medication Name:

Dosage: Dosage Unit: Frequency: ☐ Previously Reported

Add

| Medication | Dosage Amount | Dosage Unit | Frequency | Previously Reported | |
|---|---|---|---|---|---|

Save

Next

18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU NOW HAVE ANY OF THE FOLLOWING? (Click each item under the column entitled "Description" prior to responding.) Answer "yes" or "no" for every condition listed below (All "yes" answers require a comment. Click Add Comments to add or edit a comment).

1. Select "Yes" or "No" for each item ("a." through "t.").
   - Select "Yes" for every condition you've had or have been diagnosed with now or at any time in your life.
   - Select "Yes" for any condition already reported on a previous medical certificate application provided there has been no change in your condition. Use the wording "PREVIOUSLY REPORTED, NO CHANGE" in the "Applicant Explanation" box you will see once you save the form.
   - Enter a comment (in the "Applicant Explanation" box) to explain each item you marked "Yes:"
     - In your comment, describe the condition, and include the approximate date of diagnosis/occurrence.
     - Indicate whether you are taking medication (and any medication side effects), and whether you have had any hospital visits or surgery related to any item.
   - Do not report occasional common illnesses such as colds or sore throats.
2. Click the "Save" button to save the form.
   - Once you save the form, you will see the "Applicant Explanation" boxes where you will enter your comments.
   - If you get a message that says there are "validation errors" in your application, you must fix them before the comment boxes will open for you to use.

| Medical History | Description | Medical History | Description |
|---|---|---|---|
| a. ◯Yes ◯No | Frequent or severe headaches. | k. ◯Yes ◯No | Diabetes. |
| b. ◯Yes ◯No | Dizziness or fainting spell. | l. ◯Yes ◯No | Neurological disorders or impairment. |
| c. ◯Yes ◯No | Unconsciousness for any reason. | m. ◯Yes ◯No | Mental illness. |
| d. ◯Yes ◯No | Eye condition(s) or vision disturbance(s) other than standard vision correction. | n. ◯Yes ◯No | Substance dependence or substance abuse (or any substance use disorder). |
| e. ◯Yes ◯No | Hay fever or allergy. | o. ◯Yes ◯No | A DOT or any other positive drug test result or positive alcohol test result of over .04. |
| f. ◯Yes ◯No | Asthma or lung disease. | p. ◯Yes ◯No | Suicide attempt. |
| g. ◯Yes ◯No | Heart or vascular disease. | q. ◯Yes ◯No | Motion sickness. |
| h. ◯Yes ◯No | High or low blood pressure. | r. ◯Yes ◯No | Cancer. |
| i. ◯Yes ◯No | Stomach, liver, or intestinal problems/disease. | s. ◯Yes ◯No | Sleep apnea. |
| j. ◯Yes ◯No | Kidney problems/disease. | t. ◯Yes ◯No | Any other illness or disability? |
| | | u. ◯Yes ◯No | Any other hospitalization? |

Add Comments | Save | Next

(ITEM A) For example: simple headaches, recurring headaches, headaches that have required medical treatment, migraine headaches, cluster headaches, or headaches associated with visual or neurological symptoms.
(ITEM B) For example: frequent spinning or lightheadedness; other factors associated with episodes of dizziness or fainting, such as headache, nausea, loss of consciousness, tingling, numbness.
(ITEM C) For example: unconsciousness that has been incapacitating, no matter how short, explained loss of consciousness, unexplained loss of consciousness.
(ITEM D) For example: any changes in vision, unusual visual experiences (halos, wavy lines, etc.), sensitivity to light, eye injuries, eye fatigue, eye strain, loss of vision, vision discomfort, eye surgeries.
Refractive procedures such as: Radial Keratotomy (RK); Epikeratophakia; Laser-Assisted In Situ Keratomileusis (LASIK), including Wavefront-guided LASIK; Photorefractive Keratectomy (PRK); Conductive Keratoplasty (CK).
(ITEM E) For example: chronic allergies controlled by allergy shots or daily medication; seasonal allergies controlled by allergy shots, nasal allergies; nasal obstruction; sinus block; sinusitis; vertigo.
(ITEM F) For example: frequent, severe asthma attacks; use of an inhaler; COPD, chronic bronchitis, emphysema, fistula, lobectomy, fungal disease, pleurisy, pneumothorax, pulmonary embolism, pulmonary fibrosis, chest surgery, tumors.
(ITEM G) For example: angina, heart pain, anti-tachycardia device, abnormal rhythm, atrial fibrillation, cardiac decompensation, pulmonary hypertension, heart enlargement, cardiac pacemaker implantation, heart transplant, cardiac valve replacement, cardioversion, congenital heart disease, coronary heart disease, endocarditis, hypertrophy or dilatation of the heart, implantable defibrillators, heart attack, pericarditis, valvular disease, heart inflammation.
(ITEM H) For example: diagnosis of high or low blood pressure, whether treated or not; use of blood pressure medication of any kind.
(ITEM I) For example: appendicitis, appendectomy, bleeding ulcers, bowel obstruction, cancer, colostomy, gastrointestinal diseases (e.g., cirrhosis, chronic hepatitis, malignancy, colitis), irritable bowel syndrome, hernias, Crohn's disease.
(ITEM J) For example: kidney stone, kidney cancer, kidney transplant, blood in urine, pain or burning upon urination, incontinence, excessive urination, frequent urination, urinating frequently at night, urinary tract infection, sugar in the urine.
(ITEM K) For example: diagnosis with pre-diabetes, type I diabetes, type II diabetes; using insulin, an insulin pump, diabetes medication (oral or injectable), on a controlled diet.
(ITEM L) For example: epilepsy, seizures, stroke, paralysis, weakness, disturbance of sensation, disturbance of consciousness, loss of coordination, head injury, concussion.
(ITEM M) For example: anxiety, attention deficit disorder, attention deficit hyperactivity disorder, bipolar disorder, depression, panic attacks, post-traumatic stress disorder.
(ITEM N) - "Substances" include alcohol, PCP, marijuana, cocaine, amphetamines, barbiturates, opiates, and other psychoactive chemicals. A positive drug test result or alcohol test over .04 constitutes substance abuse.
- "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 use is physically hazardous; or misuse of a substance when such misuse has impaired health or social or occupational functioning.
(ITEM O) See 67.107 (b)(2); 67.207 (b)(2) and 67.307 (b)(2). [Answer "Yes" for any and all positive tests; whether administered at the Federal, State, or local level, or by a private employer, etc.]
(ITEM P) For example: thoughts of suicide, attempted suicide.
(ITEM Q) For example: unresolved, chronic motion sickness (in flight or while traveling by other vehicle) for which you must be medicated.
(ITEM R) List any cancer(s) not provided for in items a. through u.
(ITEM S) For example: diagnosed due to excessive snoring, insomnia, restless leg syndrome, interrupted breathing while sleeping, sleep study has been performed, nightly use of sleep aids prescribed (medication, CPAP, etc.)
(ITEM T) List any illness/illnesses or disability/disabilities not provided for in items a. through u.
(ITEM U) List any hospitalization(s) not already reported in the APPLICANT EXPLANATION box in relation to items a. through t.

19. In your life have you ever received any of the following?

1. Select "Yes" or "No" for each item ("a." through "d.").
   - Select "Yes" for every item that applies to you.
   - Select "Yes" for any item already reported on a previous medical certificate application. Use the wording "PREVIOUSLY REPORTED, NO CHANGE" in the "Applicant Explanation" box that you will see once you save the form.
   - Enter (in the "Applicant Explanation" box) a comment to explain each item you marked "Yes."
     - Describe the situation, and include approximate date of occurrence.
2. Click the "Save" button to save the form.
   - Once you save the form, you will see the "Application Explanation" boxes where you will enter your comments.
   - If you get a message that says there are "validation errors" in your application, you must fix them before the comment boxes will open for you to use.

a. Military medical discharge? ○ Yes ○ No

b. Medical rejection from a service of the military? ○ Yes ○ No

c. Medical disability benefits (e.g., from the Veteran's Administration, the Social Security Administration, etc.)? ○ Yes ○ No

d. Rejection for life or health insurance? ○ Yes ○ No

Add Comments

Save

Next

20. Criminal, Civil, or Military Action History:

1. Select "Yes" or "No" for each item ("a." through "e.").
   - Select "Yes" for every item that applies to you.
   - Select "Yes" for any item already reported on a previous medical certificate application. Use the wording "PREVIOUSLY REPORTED, NO CHANGE" in the "Applicant Explanation" box that you will see once you save the form.
   - Enter (in the "Applicant Explanation" box) a comment to explain each item you marked "Yes."
2. Click the "Save" button to save the form.
   - Once you save the form, you will see the "Application Explanation" boxes with the corresponding numbers (e.g. 20.a.) where you will enter your comments.

20.a.(BUBBLE: "Conviction" (for purposes of this application) means any judgment of guilt based on a jury, court, or military verdict, a plea of guilty,or a plea of nolo contendre/no contest. Examples include, but are not limited to, assault, battery, disorderly conduct, domestic violence, driving under the influence, driving while intoxicated, murder, possession of drugs, public intoxication, reckless driving, etc. If you answer yes to this question, you should report all misdemeanors and felony convictions regardless of the classification of the conviction and regardless of whether the conviction is pending on appeal to another court.)
List the charge(s) for which you were convicted, the date of the conviction, and the state, federal, military, or foreign court in which you were convicted. If a conviction has been reversed or vacated in a final judgment, state the date of the final judgment and the court that issued the final judgment. If the record of a conviction has been expunged, state the date that the record was expunged and the court that ordered the expunction.

20.b. List, for each denial, suspension, cancellation, or revocation of your driver's license or driving privileges, the U.S. state, U.S. military base, or foreign country where the action occurred, the specific type of action taken (for example, the driver's license was denied, suspended, cancelled, or revoked), the date each action was taken, and the basis for the action.

20.c. (BUBBLE: Examples of educational or rehabilitation programs include, but are not limited to, anger management program(s), drug or alcohol treatment program(s), safe driving course(s), etc.)
List the type of educational or rehabilitation program you were required to attend as part of a criminal, civil, or military action (including non-judicial punishment), the entity that required you to attend, and the date(s) and place(s) of your attendance.

20.d. List the date, place, and circumstances of each of your refusals to take any Breathalyzer test, any blood alcohol test, or any drug test. State whether each refusal to take any Breathalyzer test, any blood alcohol test, or any drug test resulted in your driving privileges being denied, suspended, cancelled, or revoked and/or in your having to pay a monetary fine.

20.e. (BUBBLE: For purposes of this application "arrest" means being detained or taken into custody by any law enforcement or military authority for any reason related to a driving stop for suspected driving while intoxicated by, while impaired by, or under the influence of drugs or alcohol.)
List, for each arrest, the place, date, and circumstance(s) of the arrest.

| **Arrest and/or Conviction and/or Administrative Action History - IN YOUR LIFE HAVE YOU EVER:** | |
|---|---|
| a. ○ Yes ○ No | Been convicted of any type of misdemeanor or felony? |
| b. ○ Yes ○ No | Had any driver's license or driving privileges denied, suspended, cancelled, or revoked for any reason? |
| c. ○ Yes ○ No | Been required to attend an educational or rehabilitation program in connection with a denial, suspension, cancellation, or revocation of driver's license or driving privileges? |
| d. ○ Yes ○ No | Refused for any reason to take any Breathalyzer test, any blood alcohol test, or any drug test? |
| e. ○ Yes ○ No | Been arrested for any reason related to driving while intoxicated by, while impaired by, or under the influence of drugs or alcohol? |

Add Comments

Save

Next

21. Have you visited any health professionals within the last 3 years ○ Yes ○ No

1. Select "Yes" or "No."
2. If you selected "Yes" you must enter the following:
   - All visits in the last 3 years to any health professionals [such as a physician, physician assistant, nurse practitioner, psychologist, psychiatrist, chiropractor, clinical social worker, or substance abuse specialist (including an EAP employer-sponsored specialist)] for treatment, examination, or medical/mental evaluation. (Enter each visit, even if it is to the same professional for the same condition.)
   - Note: You do not need to enter the following:
     - Routine dental and eye examinations.
     - Periodic FAA medical examinations and visits to health professionals related to an Authorization for Special Issuance. (The FAA already has recorded these visits.)
3. Click the "Add" button.
4. Repeat steps 1, 2, and 3 to add all visits to health professionals within the past 3 years.
   - You will see your visit information (e.g., Date, Name, Address, etc.) displayed in the chart below your individual entries.
   - You may update or delete information by clicking the "Edit" or "Delete" link displayed to the right of each visit listed in the chart.

**Enter your information in the spaces provided and click the Add button.**
**Note: You must click the add button to make additional entries.**

Date of visit (MM/YYYY): Name: Address (Number/Street):

City: State: Zip Code: Country:

Type of Professional: Reason for Visit: Add

| Date of Visit | Name | Address (Number/Street) | City | State | Zip Code | Country | Type of Professional | Reason for Visit | | |
|---|---|---|---|---|---|---|---|---|---|---|

Save

Next

**22. Applicant's National Driver Register and Certifying Declaration:**

I authorize the National Driver Register (NDR), through a designated state Department of Motor Vehicles, to give the FAA information about my driving record. This consent authorizes the FAA a single access to my NDR record to verify the information I gave in this application. I understand that, upon written request, the FAA will provide me with copies of any information it receives from the NDR for my review and comment. Authority: 23 U.S. Code 401, Note.

NOTE: ALL persons who use this form must sign it. NDR consent, however, does not apply unless this form is used as an application for an FAA Airman Medical Certificate.

I certify that all statements and answers I entered on this application form are complete and true to the best of my knowledge. I agree that the FAA may consider them in deciding whether to issue a certificate to me. I also read the Privacy Act statement and the Pilot Bill of Rights information that accompanies this form.

Certifying Declaration:

When I sign, date, and submit this form, I (the applicant) certify that I have:

- Completed this application myself;
- Provided statements and answers that are true and complete to the best of my knowledge and understand that the FAA will consider my statements and answers to decide whether to issue an FAA airman medical certificate to me; and
- Read the Privacy Act and Pilot Bill of Rights Statements.

( ) Yes ( ) No

Applicant Name: Date (DD/MM/YYYY):

Save Next

True and Complete Bubble:
- NOTICE -
Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully 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).

Your application is not complete until you enter your password and press the "Submit" button at the bottom of this page.

I am not done yet. Save my application so I can finish it later. Save

Show me any errors I have made on my application. Show Validation Errors

Make sure that your application is complete and accurate before you submit it. By entering the login password you are certifying that you agree with the National Driver Register and Certifying declarations. If you are satisfied that all your information is accurate to the best of your knowledge, click on the "Submit" button. You may only submit an application once. Once you enter your password and submit the application you will not be able to access it again.

I understand that when I enter my password, I certify that I agree with the National Driver Register and Certifying Declarations. I further understand that I will not be able to change my application after I submit the information (only my AME will be able to access my application at the time of my physical exam).

I'm done. Send my application to the FAA. Password: Submit

AFTER THEY SUBMIT, this pop-up should appear

REMINDERS: When you go to the AME for your examination:
1. Bring any medical documentation or prescription medication that may facilitate a more efficient examination. Consider, for example, any recent x-rays, notes from a specialist, etc.
2. Bring government-issued photo identification (proof of identity) as required under the Application requirements of 14CFR§67.4.