## Privacy Act Statement

This statement is provided pursuant to the Privacy Act of 1974, 5 USC § 552a.

**Authority**: The authority for collecting this information is contained in 49 U.S.C. 44703, and 14 CFR 61.31.

**Purpose**: The FAA will to use the information for enrollment of, qualifying for, managing and maintaining documentation of flight crew members who attend and complete the Physiological Training course conducted at the Civil Aerospace Medical Institute (CAMI) in Oklahoma City.

**Routine Use**: In accordance with Privacy Act System of Records DOT/FAA 828, titled "Physiological Training System".

**Disclosure**: Provision of the requested information is voluntary; however failure to furnish the requested information may result in an inability of the CAMI to provide the requested training.

| Physiological Training Record | | | |
|---|---|---|---|
| ***Last Name*** ***First Name*** ***Middle Initial*** | | | ***Duty Routing Symbol / Organization*** |
| ***FAA Medical Certificate Examiner's Designation # or Form Control #*** | ***BasicMed Physicians Name*** | ***Date of FAA Medical Certificate / BasicMed Examination*** | ***Today's Date*** |

**If you desire to participate in altitude chamber or PROTE flight today, please answer the following questions:**

**Age:_____ Height:_____ Weight:_____ No. of Flt. Hours:_____ No. Prior Chamber Experiences:_____**

***(Check the appropriate answer)***

| | | |
|---|---|---|
| **Are you taking any medications that were not approved at the time of your last FAA medical exam?** | ***YES*** ☐ | ***NO*** ☐ |
| **Do you have a cold or nasal congestion?** | ***YES*** ☐ | ***NO*** ☐ |
| **Do you have an ear infection now or have you had an ear infection in the past 30 days?** | ***YES*** ☐ | ***NO*** ☐ |
| **Do you have a history of significant ear pressure blocks during flying?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you had a ruptured eardrum since your last FAA medical exam?** | ***YES*** ☐ | ***NO*** ☐ |
| **Do you have any symptoms of upset stomach, gas, or diarrhea?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you had any operations or been hospitalized within the last 90 days?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you been unconscious because of illness or injury within the past 12 months?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you ever had convulsions or been evaluated for possible epilepsy?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you ever had any disease or surgery of the heart or vascular system?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you ever had any disease or surgery of the lungs or chest?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you participated in scuba diving during the last 24 hours?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you donated blood in the past 72 hours?** | ***YES*** ☐ | ***NO*** ☐ |
| **Do you have a low hematocrit or hemoglobinopathy (such as sickle cell anemia)?** | ***YES*** ☐ | ***NO*** ☐ |
| **Have you had altitude sickness or prior problems with hypoxic exposure including chamber flight?** | ***YES*** ☐ | ***NO*** ☐ |

***(FEMALES ONLY)***

| | | |
|---|---|---|
| **Is there a possibility that you are pregnant?** | ***YES*** ☐ | ***NO*** ☐ |

**Briefly explain all *YES* answers:**_____

_____

### *CONSENT FOR RELEASE OF DATA AND ASSUMPTION OF RISK*

In consideration of the approval of this training and of the receiving of the proposed physiological training, and of the professional, aeronautical, and personal benefits to be gained therefrom, I voluntarily assume all risk of accident or damage to my person and property, and do hereby for myself and my heirs, executors, and administrators, release the United States and its executive offices and agencies (together with its officers, agents, and employees) from all claims, demands, and causes of action founded in personal harm occurring during the physiological training.

In order to minimize the risk associated with this hypoxia training exposure, I will wear a pulse oximeter during the exposure and will terminate my hypoxia exposure if my oxygen saturation drops below 60%.

And in addition, I hereby authorize any medical treatment necessary for conditions that may arise in connection with or as a result of this training and understand that I am responsible for payment for any and all services required for said treatment.

_____ _____

Signature Date