Transport Canada Transports Canada

PROTECTED "B" WHEN COMPLETED

CIVIL AVIATION MEDICAL EXAMINATION REPORT

Has your mailing address changed since your last medical?
◯ Yes ◯ No

PART A (To be completed by applicant)

Type of medical category desired	Aviation medical category held	Permit or Licence number 5802-
Given Names	Family Name	Former name

Address (Number, street, apartment)

City	Province	Country	Postal Code

Telephone number (999-999-9999)	Business telephone (999-999-9999)	Cell number (999-999-9999)	E-mail

Date of Birth (yyyy-mm-dd)	Gender ◯ Male ◯ Female	Citizenship	Language of correspondence ◯ English ◯ French

Aircraft/vehicle accident since last exam? ◯ Yes ◯ No	Pilot flying time last 12 months	Refusal of issue or renewal of medical certificate? ◯ Yes ◯ No

Have you consulted a physician or other health care provider since your last aviation medical? ◯ No ◯ Yes (if yes, provide details)

If you are in receipt of a pension or other compensation for injury, please list the associated medical conditions.

PART B – CIVIL AVIATION MEDICAL EXAMINER'S RECOMMENDATION (to be completed after medical examination)

RECOMMENDATION

CAME Stamp

Category: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Deferred to RAMO

The medical certificate was ◯ renewed ◯ not renewed ◯ new applicant

Do you recommend further examination? ◯ Yes ◯ No

Date (yyyy-mm-dd) _____ Telephone (999-999-9999) _____ CAME Signature _____

STATEMENT OF APPLICANT

I hereby declare that I have read and understood the information contained herein, which to the best of my knowledge is complete and correct. I recognize that this report and any other medical documentation submitted or authorized to be submitted by me as part of my application for licence or permit is the property of Transport Canada Civil Aviation Medical Advisors.

I am aware that it is an offence under the *Aeronautics Act* to knowingly make a false representation for the purpose of obtaining a Canadian aviation document or any privilege accorded thereby.

Date (yyyy-mm-dd) _____ Applicant's signature _____ Witness _____

RAMO ASSESSMENT (Departmental Use Only)

1st Category _____ Code(s) _____ _____ _____

2nd Category _____ Code(s) _____ _____ _____

Path Code(s) _____ _____

Comments / Restrictions

RAMO Signature _____ Date (yyyy-mm-dd) _____

Entered in CAMIS _____

Canada

Name	Permit or Licence number	Date of Birth (yyyy-mm-dd)	Date of examination (yyyy-mm-dd)
	5802-		

PART C (To be completed by examiner)

REVIEW OF SYSTEMS

Has the applicant ever had or been treated for any of the following conditions?

1. Head injury, dizziness, loss of consciousness	◯ Yes	◯ No	7. Frequent or severe headaches, migraines	◯ Yes	◯ No
2. Neurological problems, epilepsy, seizures	◯ Yes	◯ No	8. Psychiatric, anxiety, depression, ADHD	◯ Yes	◯ No
3. Ear disease or deafness	◯ Yes	◯ No	9. Pulmonary disorders including asthma, COPD, OSA	◯ Yes	◯ No
4. Gastrointestinal disorders	◯ Yes	◯ No	10. Cardiovascular disorders, hypertension, coronary artery disease, arrhythmia	◯ Yes	◯ No
5. Genito-urinary disorders	◯ Yes	◯ No	11. Musculo - skeletal disorders	◯ Yes	◯ No
6. Alcohol or substance abuse, impaired driving events	◯ Yes	◯ No	12. Any other medical conditions, diabetes, cancer	◯ Yes	◯ No

Does the applicant have a significant family history of ischemic heart disease (first degree relative with an event before age 55 (if male) or 60 (if female) ?

◯ Yes ◯ No

Examiner please elaborate (List injuries, operations, serious illnesses and dates) (additional space is available on page 3)

In the past twelve months has the applicant:

1. Used therapeutic medications (prescription, OTC, herbal, etc)?	◯ Yes	◯ No	
2. Consumed a tobacco and/or nicotine product?	◯ Yes	◯ No	
3. Consumed alcohol?	◯ Yes	◯ No	if "yes" average units per week _____
4. Used any drugs (including cannabis) for non-medical reasons?	◯ Yes	◯ No	if "yes" please list _____

Examiner please elaborate (list all that apply and dates) (additional space is available on page 3)

PHYSICAL EXAMINATION

Height (cm)	Weight (kg)	BMI	Blood pressure	Pulse

Urinalysis: Glucose _____ Other _____

Check each item

1. Nutrition	◯ Norm	◯ Abnormal	5. Nose and Throat	◯ Norm	◯ Abnormal	9. Ears	◯ Norm	◯ Abnormal
2. Respiratory system	◯ Norm	◯ Abnormal	6. Cardiovascular	◯ Norm	◯ Abnormal	10. Gastro Intestinal	◯ Norm	◯ Abnormal
3. Genito-urinary	◯ Norm	◯ Abnormal	7. Locomotor	◯ Norm	◯ Abnormal	11. Neurological	◯ Norm	◯ Abnormal
4. Mental status	◯ Norm	◯ Abnormal	8. Integument	◯ Norm	◯ Abnormal			

Elaborate on each abnormal response with diagnosis if possible (additional space is available on page 3)

VISUAL EXAMINATION

Acuity

Distant	Right Eye ____ / ____	Corrected to ____ / ____	◯ Glasses	
	Left Eye ____ / ____	Corrected to ____ / ____	◯ Contact lenses	
	Both Eyes ____ / ____	Corrected to ____ / ____		
Near	N5 @ 30-50 cm	Uncorrected ◯ Yes ◯ No		
		Corrected ◯ Yes ◯ No		

Ocular Muscle Balance (Cover Test)

Ortho ◯ Yes ◯ No

If not Ortho please check which applies below:

Hyper ◯ Yes ◯ No Eso ◯ Yes ◯ No

Exo ◯ Yes ◯ No

Optic Fundi ◯ Normal ◯ Abnormal

Visual Fields ◯ Normal ◯ Abnormal

Has the applicant had refractive surgery? ◯ Yes ◯ No

Colour Perception Examination

Pseudoisochromatic Plates	Type	Number of plates	Number of errors

HEARING EXAMINATION

Does the applicant pass the whispered voice test at 2m (6ft)? Right ◯ Yes ◯ No Left ◯ Yes ◯ No

Audiogram / Audioscope (if applicable)

HZ	500	1000	2000	3000	4000
Right					
Left					

Additional space for comments is available on page 3

Canada

Name	Permit or Licence number 5802-	Date of Birth (yyyy-mm-dd)	Date of examination (yyyy-mm-dd)
Additional comments (e.g. history, physical)			

CAME Stamp

Signature

Date (yyyy-mm-dd)

Canada