CIVIL AVIATION MEDICAL EXAMINATION REPORT

PART A

Has the applicants mailing address changed since their last medical? ◯ Yes ◯ No

Type of medical category desired	Aviation medical category held	Permit or Licence number 5802-
Given Names	Family Name	Former Surname
Home Address (Number, street, apartment)		
City	Province	Country / Postal Code

Is the home address the same as the mailing address? ◯ Yes ◯ No (if no, provide details)

Mailing 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)	Sex ◯ Male ◯ Female	Citizenship	Language of correspondence ◯ English ◯ French
Employer	Education		

Has the applicant undergone a practical flight test to assess medical fitness to fly? Example: Cockpit assessment due to hearing loss.

◯ No ◯ Yes (if yes, provide details)

Aircraft/vehicle accident since last exam? ◯ Yes ◯ No

Pilot flying time last 12 months	Pilot total flying time

Refusal of issue or renewal of medical certificate? ◯ Yes ◯ No

Has the applicant consulted a physician or other health care provider since their last aviation medical? ◯ No ◯ Yes (if yes, provide details)

Is the applicant in receipt of a pension or other compensation for injury? ◯ No ◯ Yes (if yes, please list all associated medical conditions)

Entered in CAMIS _____

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

PART B (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	10. Cardiovascular disorders, hypertension, coronary artery disease, arrhythmia	◯ Yes	◯ No
2. Neurological problems, epilepsy, seizures	◯ Yes	◯ No	11. Musculo - skeletal disorders	◯ Yes	◯ No
3. Ear disease or deafness	◯ Yes	◯ No	12. Allergies	◯ Yes	◯ No
4. Gastrointestinal disorders	◯ Yes	◯ No	13. Menstrual Issues	◯ Yes	◯ No
5. Genito-urinary disorders	◯ Yes	◯ No	14. Vision or eye problems including refractive surgery, cataract surgery, orthokeratology, or intraocular lens implants	◯ Yes	◯ No
6. Alcohol or substance abuse, impaired driving events	◯ Yes	◯ No			
7. Frequent or severe headaches, migraines	◯ Yes	◯ No	15. Diabetes	◯ Yes	◯ No
8. Psychiatric, anxiety, depression, ADHD	◯ Yes	◯ No	16. Cancer	◯ Yes	◯ No
9. Pulmonary disorders including asthma, COPD, OSA	◯ Yes	◯ No	17. Any other medical conditions	◯ 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

Please Elaborate on all positive responses above; List relevant family history, past surgical history, and serious illnesses (additional space is available on page 3).

In the past twelve months has the applicant:

1. Used ANY medication to treat a medical condition? (This includes prescription, non-prescription, over-the-counter, herbal medications, cannabis, or cannabis-derived products. *Examples: acetaminophen for backpain, cannabis for anxiety, cannabidiol (CBD) for chronic pain*) ◯ Yes ◯ No

(If yes, please list medication name, dose, and route of administration, frequency, and reason for use)

2. Used tobacco or any product containing nicotine? This includes cigarettes, vaping devices, gum, hookah, cigars, or nicotine patches? ◯ Yes ◯ No

(If yes, please list Product name or type, dose, route of administration, and frequency)

3. Used alcohol? (If yes, average units per week): _____ ◯ Yes ◯ No

4. Used Cannabis or cannabis derived product for non-medical purposes? ◯ Yes ◯ No

5. Used any other drug or substance (excluding cannabis and alcohol), for recreational or non-medical purposes? ◯ Yes ◯ No

(If yes, please list)

Additional Comments

Canada

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

PHYSICAL EXAMINATION

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

Urinalysis:

Glucose: ◯ Yes ◯ No Blood: ◯ Yes ◯ No Other: ◯ Yes ◯ No (specify:) _____

Check each item

1. Nutrition	◯ Norm	◯ Abnormal	5. Abdomen	◯ Norm	◯ Abnormal	9. Ears	◯ Norm	◯ Abnormal
2. Respiratory system	◯ Norm	◯ Abnormal	6. Cardiovascular	◯ Norm	◯ Abnormal	10. Gastro Intestinal	◯ Norm	◯ Abnormal
3. Head and Neck	◯ Norm	◯ Abnormal	7. Locomotor	◯ Norm	◯ Abnormal	11. Neurological	◯ Norm	◯ Abnormal
4. Mental status	◯ Norm	◯ Abnormal	8. Skin, nails, and hair	◯ Norm	◯ Abnormal			

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

VISUAL EXAMINATION

Corrected with: ◯ Glasses ◯ Contact Lenses ◯ N/A

Unaided 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

Please select the test performed

◯ Cover ◯ Maddox Rod ◯ Other

(if Maddox Rod, provide the diopters and detail any other vision tests preformed): _____

Hyperphoria ◯ Yes ◯ No

Esophoria ◯ Yes ◯ No

Exophoria ◯ Yes ◯ No

Optic Fundi ◯ Normal ◯ Abnormal

Visual Fields ◯ Normal ◯ Abnormal

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					

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

Electrocardiogram required for this exam ◯ Yes ◯ No

Category Renewed by CAME – Category: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Not Renewed

Deferred by CAME: ☐ Initial Applicant ☐ For evaluation by RAMO

Do you recommend further examination? ◯ Yes ◯ No

☐ The CAME has reviewed and submitted all documents relevant to medical fitness for aviation

CAME Stamp

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 _____

Canada

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

CAME Additional Comments (e.g. history, physical, aviation medical fitness analysis, recommendations)

RAMO ASSESSMENT (Departmental Use Only)

1st Category _____ Code(s) _____ _____ _____

2nd Category _____ Code(s) _____ _____ _____

Path Code(s) _____ _____

Comments / Restrictions

_____ RAMO Signature

_____ Date (yyyy-mm-dd)

Canada