

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT

Copy of FAA Form 8500-9 (Medical Certificate) or FAA Form 8420-2 (Medical/Student Pilot Certificate) issued. **FOR REFERENCE ONLY**  
**MEDICAL CERTIFICATE CLASS AND STUDENT PILOT CERTIFICATE**

This certifies that (Full name and address):

Date of Birth	Height	Weight	Hair	Eyes	Sex
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has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

**Limitations**  
**THIS FORM CANNOT BE USED IN LIEU OF TURBOMEDICAL OR FAA MEDXPRESS.**

Date of Examination: \_\_\_\_\_ Examiner's Designation No.: \_\_\_\_\_

**Examiner**  
Signature: \_\_\_\_\_  
Typed Name: \_\_\_\_\_

**AIRMAN'S SIGNATURE**

1. Application For:  Airman Medical Certificate  Airman Medical and Student Pilot Certificate  
2. Class of Medical Certificate Applied For:  1st  2nd  3rd

3. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

4. Social Security Number \_\_\_\_\_

5. Address \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

Number / Street \_\_\_\_\_

City \_\_\_\_\_ State / Country \_\_\_\_\_ Zip Code \_\_\_\_\_

6. Date of Birth \_\_\_\_\_ 7. Color of Hair \_\_\_\_\_ 8. Color of Eyes \_\_\_\_\_ 9. Sex \_\_\_\_\_  
M M / D D / Y Y Y Y  
Citizenship \_\_\_\_\_

10. Type of Airman Certificate(s) You Hold:  
 None  ATC Specialist  Flight Instructor  Recreational  
 Airline Transport  Flight Engineer  Private  Other  
 Commercial  Flight Navigator  Student

11. Occupation \_\_\_\_\_ 12. Employer \_\_\_\_\_

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked?  
 Yes  No If yes, give date \_\_\_\_\_  
M M / D D / Y Y Y Y

Total Pilot Time (Civilian Only)  
14. To Date \_\_\_\_\_ 15. Past 6 Months \_\_\_\_\_ 16. Date of Last FAA Medical Application \_\_\_\_\_  
M M / D D / Y Y Y Y  No Prior Application

17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)?  
 No  Yes (If yes, below list medication(s) used and check appropriate box).  
Previously Reported: Yes  No   
     
(If more space is required, see 17. a. on the instruction sheet).

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying?  Yes  No

18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. See Instructions Page

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a.	<input type="checkbox"/>	Frequent or severe headaches	g.	<input type="checkbox"/>	Heart or vascular trouble	m.	<input type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.	r.	<input type="checkbox"/>	Military medical discharge
b.	<input type="checkbox"/>	Dizziness or fainting spell	h.	<input type="checkbox"/>	High or low blood pressure	n.	<input type="checkbox"/>	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.	s.	<input type="checkbox"/>	Medical rejection by military service
c.	<input type="checkbox"/>	Unconsciousness for any reason	i.	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	o.	<input type="checkbox"/>	Alcohol dependence or abuse	t.	<input type="checkbox"/>	Rejection for life or health insurance
d.	<input type="checkbox"/>	Eye or vision trouble except glasses	j.	<input type="checkbox"/>	Kidney stone or blood in urine	p.	<input type="checkbox"/>	Suicide attempt	u.	<input type="checkbox"/>	Admission to hospital
e.	<input type="checkbox"/>	Hay fever or allergy	k.	<input type="checkbox"/>	Diabetes	q.	<input type="checkbox"/>	Motion sickness requiring medication	x.	<input type="checkbox"/>	Other illness, disability, or surgery
f.	<input type="checkbox"/>	Asthma or lung disease	l.	<input type="checkbox"/>	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	y.	<input type="checkbox"/>	Medical disability benefits			

Arrest, Conviction, and/or Administrative Action History --- See Instructions Page  
v.  Yes  No History of (1) any arrest(s) and/or conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any arrest(s), and/or conviction(s), and/or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.  
w.  Yes  No History of nontraffic conviction(s) (misdemeanors or felonies).

Explanations: See Instructions Page **FOR FAA USE**  
Review Action Codes

19. Visits to Health Professional Within Last 3 Years.  Yes (Explain Below)  No See Instructions Page

Date	Name, Address, and Type of Health Professional Consulted	Reason

— NOTICE —  
Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willingly 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).

20. Applicant's National Driver Register and Certifying Declarations  
I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S Code 401, Note.  
**NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.**  
I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.  
Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_  
M M / D D / Y Y Y Y