CAAM/MED/7

CIVIL AVIATION AUTHORITY OF MALAYSIA

CABIN CREW MEDICAL APPLICATION AND EXAMINATION REPORT

MEDICAL IN CONFIDENCE

(1) Full Name:			(2) Staff No:	
(3) Number of Years as Cabin Crew:			(4) IFME Training Date:	
(5) NRIC/Passport No:	(6) DOB:	Age:	(7) Sex Male: ☐ Female: ☐	(8) Application Initial: ☐ Renewal: ☐
(9) Place & Country of Birth:	(10) Nationality:		(11) Occupation (principal)	
(12) Permanent Address: Country: Telephone No: Mobile No: E-mail:	(13) Postal Address: (If different) Country: Telephone No: Mobile No: E-mail:		(14) Employer: (15) Last Cabin Crew medical examination: Date: Place: (16) Any Conditions/Limitations/Variations on the Licence/Medical Cert: No: ☐ Yes: ☐	
(17) If Yes to (16) please provide details:			(18) GP Name:Address: Telephone No:	
(19) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? If yes, discuss with the Doctor No: ☐ Yes: ☐ Date: Place: Details:			(20) Total flight time hours: (22) Aircraft type presently flying:	(21) Flight time hours since last medical:
(23) Any aircraft accident or incident since last medical? No ☐ Yes ☐ Date: Place: Details:				
(24) Do you drink alcohol? No ☐ Yes: ☐ If Yes, state average weekly intake in units:				
(25) Do you smoke? No: ☐ Yes: ☐ Amount of Sticks per day: No of Years: Stopped: ☐				
(26) Do you currently use any medication: No: ☐ Yes: ☐ If Yes, state name of drug, dose, date started and why				

General and Medical History: Do you have, or have you ever had, any of the following? NO or YES (or as indicated) must be ticked after each question. Elaborate YES answers in the remarks in the remark section.

	No	Yes		No	Yes		No	Yes	FEMALE ONLY	No	Yes
(27) Eye trouble/operation			(36) Nose, throat or speech disorder			(46) Malaria or other tropical disease			(56) Gynaecologyor menstrual problem		
(28) Spectacles/contact lens ever worn			(37) Head injury or concussion			(47) Tuberculosis			(57) Pregnant. If Yes LMP.		
(29) Hay fever, allergy			(38) Frequent or severe headaches or migraine			(48) Skin diseases			**FAMILY HISTORY OF:**		
(30) Asthma, lung disease			(39) Black out for any reason			(49) Admission to hospital			(58) Heart disease		
(31) Heart or vascular			(40) Stroke, epilepsy, fits, paralysis, body weakness			(50) Any other illness or injury			(59) High blood pressure		
(32) High or low blood pressure			(41) Psychological, psychiatric problem			(51) Visit to Doctor sincelast medical			(60) Diabetes		
(32) Kidney stone or blood in urine			(42) Alcohol/drug/ Substance abuse			(52) Refusal of life insurance			(61) Epilepsy		
(33) Diabetes, thyroid orhormone problem			(43) Attempted suicide			(53) Refusal of medicalcertificate for cabin crew			(62) Mental Illness		
(34) Stomach, liver orgastro-intestinal problem			(44) Motion sickness requiring medication			(54) Medical rejection fromor military service			(63) Tuberculosis		
(35) Deafness or ear disorder			(45) Anaemia, sickle cell, blood disorder			(55) Award for pension or compensation for injury			(64) Others		

(65) **Remarks**: If previously reported and no change since, so state.

(66) **Declaration:** I hereby declare that I have carefully considered the statements made above and to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statements in connection with this application, or fail to release the supporting medical information, the Doctor may refuse to grant me a medical certificate or withdraw any medical certificate granted, without prejudice to any other action applicable under national law.

CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. I understand, that if I have made any false or misleading statements in connection with this application, or fail to release the supporting medical information, the CAAM may refuse to grant me a medical certificate or may withdraw any medical certificate granted, without prejudice to any other action applicable under national law.I hereby authorize the release of all information contained in this report and any or all its attachments and all information which I have provided to the CAAM and that relates to me to my DME and, where necessary, to:

i. the Medical Assessor of CAAM; and
ii. the Medical Assessor of the competent authority of my DME; and
iii. other health professionals and administration staff

as part of the medical assessment process. I recognize that these documents or electronically stored data are to be used for completion of a medical assessment and for oversight purposes, providing that I or my physician may have access to them according to national law. The medical record will become and remain the property of the CAAM. Medical confidentiality will be respected at all times.

Date: .....Name and signature of Applicant::..... Name and signature of Doctor: .....

CIVIL AVIATION AUTHORITY OF MALAYSIA **CAAM/MED/7**

CABIN CREW MEDICAL EXAMINATION REPORT **MEDICAL IN CONFIDENCE**

Name:			Date of Birth:	MyKad No: Staff No:			
Examination Category: Initial ☐	Height: cm	BMI:	Hair colour:	Blood Pressure:		Pulse – resting	
Renewal ☐	Weight: kg	Waist Circ: cm	Eye colour:	Systolic	Diastolic	Rate	Rhythm

Clinical examination: Check each item	Normal	Abnormal		Normal	Abnormal
Head, neck, face, scalp			Abdomen, hernia, live, spleen		
Mouth throat, teeth			Anus, rectum		
Nose, sinuses			Genito-urinary system		
Ears, drums, eardrum mobility			Endocrine system		
Eyes – orbit, adnexa, visual field			Upper and lower limbs & joint		
Eyes – pupils and optic fundi			Spine, other musculo-skeletal		
Eyes – ocular motility, nystagmus			Neurological		
Lungs, chest, breaths			Psychiatric		
Heart			Skin, marks, lymphatic		
Vascular system			General systemic		
Describe every abnormal finding (attach separate paper if required).				Marks, scars, tattoo	

Visual Acuity

Distant vision	Uncorrected	Corrected
Right Eye		
Left Eye		
Both Eyes		

Intermediate vision N14 at 100cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right Eye				
Left Eye				
Both Eyes				

Near vision N5 at 30-50cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right Eye				
Left Eye				
Both Eyes				

Urinalysis	Normal ☐	Abnormal ☐	Haemoglobin: g/dl
Glucose	Protein	Blood	Others

Other tests	Not Done	Date Done	Normal	Abnormal
Fasting Blood Sugar				
Fasting Blood Lipids				
Chest X-Ray				
Audiogram				
Urine For Drugs				
Other Test				

Blood Group	

Glasses	Contact Lenses
Yes ☐ No ☐ Type:	Yes ☐ No ☐ Type:
Colour Vision Pseudo-Isochromatic: Pass ☐ Fail ☐ Additional Test (if necessary)	

Hearing Conversational voice test at 2m back turned to examiner	Right Ear	Left Ear
	Yes ☐ No ☐	Yes ☐ No ☐

DME recommendation

Name of applicant: _____

Fit ☐ Temporary Unfit ☐ Unfit ☐

If Temporary Unfit, state why

Referred to:

If Unfit, state why

Comments, restrictions, limitations:	Due dates of next medical and tests:	
	Medical:	Urine:
	FBS:	FSL:
	CXR	Audio:

MEDICAL EXAMINER'S DECLARATION: I hereby certify that I have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

Place and Date	DME Name and Address	For Official Use
CMA/DME Signature	E-mail: Telephone No: Mobile No:	