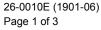


## CIVIL AVIATION MEDICAL EXAMINATION REPORT

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

PART A (To be completed by appl	licant)							
Type of medical category desired		Aviation medical category held		Permit or Licence number				
				5802-				
Given Names		Family Name	Family Name		Former name			
Address (Number, street, apartme	nt)							
City		Province			Country	Postal Code		
Telephone number (999-999-9999)	· (999-999-9999) Business telepho		Cell number (999-999-999	ell number (999-999-9999)				
Date of Birth (yyyy-mm-dd)	Gender	Citizenship Female		Language of corre		ndence		
	Male (				English French			
Aircraft/vehicle accident since last	exam?	Pilot flying time last 12 months			Refusal of issue or renewal of medical certificate?			
Yes No			Yes No					
Have you consulted a physician or	other health care	provider since vo	ur last aviation medical?	No	0 0	provide details)		
		. ,		$\bigcirc$				
If you are in receipt of a pension or	r other compensat	ion for injury, plea	se list the associated med	dical condit	ions.			
PART B – CIVIL AVIATION MEDI	CAL EXAMINER	S RECOMMEND	ATION (to be completed a	after medica	al examination)			
RECOMMENDATION					_	CAME Stamp		
Category: 1 2	3 4	Deferred to	RAMO					
			<u> </u>					
The medical certificate was Orenewed Onot renewed Onew applicant								
Do you recommend further examination	ation? OYes	◯ No						
Date (yyyy-mm-dd) Telephone (999-999-9999) CAME Signature								
STATEMENT OF APPLICANT								
I hereby declare that I have read a	nd understood the	information conta	ained herein. which to the	best of mv	knowledge is complete	e and correct. I recognize that		
this report and any other medical of	locumentation sub	mitted or authoriz	ed to be submitted by me	as part of	my application for licer	nce or permit is the property of		
Transport Canada Civil Aviation M	edical Advisors.							
I am aware that it is an offence und		s Act to knowingly	y make a false representa	tion for the	purpose of obtaining a	a Canadian aviation document		
or any privilege accorded thereby.								
Date (yyyy-mm-dd)		Applicant's signat	ure		Witne	ess		
RAMO ASSESSMENT (Departme	ental Use Only)							
Con			Comments	Restrictions				
1st Category Code(s)		Oonmond						
2nd Category	Code(s)							
Path Code(s)								
			RAMO	Signature		Date (yyyy-mm-dd)		
Entered in CAMIS								
26-0010E (1901-06)	_					Canadä		
Page 1 of 3						Variaua		



## PROTECTED "B" WHEN COMPLETED

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 of	conditions?									
1. Head injury, dizziness, loss of consciousness OYes O	No 7. Frequent or severe h	neadaches, migraines	○Yes ○No							
2. Neurological problems, epilepsy, seizures	No 8. Psychiatric, anxiety,	depression, ADHD	⊖Yes ⊖No							
3. Ear disease or deafness	No 9. Pulmonary disorders	9. Pulmonary disorders including asthma, COPD, OSA (Yes No								
	•	10. Cardiovascular disorders, hypertension, coronary artery								
5. Genito-urinary disorders	No 11 Musculo skolotal d									
events Does the applicant have a significant family history of ischemic hea	12. Any other medical c	onditions, diabetes, cancer	$\bigcirc$ Yes $\bigcirc$ No							
		itti ali event belore age 55 (il i								
Yes No Examiner please elaborate (List injuries, operations, serious illness)	os and datos) (additional space i	s available on page 3)								
	es and dates) (additional space i	s available on page 3)								
In the past twelve months has the applicant:										
1. Used therapeutic medications (prescription, OTC, herbal, etc)?										
2. Consumed a tobacco and/or nicotine product?	()Yes ()No									
3. Consumed alcohol?		age units per week								
4. Used any drugs (including cannabis) for non-medical reasons?	○ Yes ○ No if "yes" pleas	e list								
Examiner please elaborate (list all that apply and dates) (additional	space is available on page 3)									
PHYSICAL EXAMINATION										
Height (cm) Weight (kg) BI	MI BI	lood pressure	Pulse							
Urinalysis: Glucose Other										
Check each item										
1. Nutrition ONorm Abnormal 5. Nose and	d Throat () Norm () Abnorm	al 9. Ears	Norm Abnormal							
2. Respiratory system Norm Abnormal 6. Cardiova										
3. Genito-urinary Norm Abnormal 7. Locomoto		Norm Abnormal 10. Castro intestinal Norm Abnormal   Norm Abnormal 11. Neurological Norm Abnormal								
4. Mental status Norm Abnormal Abnormal Norm Abnormal Abnormal										
Elaborate on each abnormal response with diagnosis if possible (ac										
VISUAL EXAMINATION										
		Ocular Muscle Balance (	Cover Test)							
Acuity		· · · ·	Cover rest)							
Right Eye / Corrected to		Ortho ()Yes ()No								
Distant Left Eye / Corrected to		f not Ortho please check which								
Both Eyes / Corrected to		Hyper OYes ONo	Eso ()Yes ()No							
			Exo Yes No							
Near N5 @ 30-50 cm Uncorrected OYes No		Dptic Fundi ONormal								
Corrected ()Yes ()No		/isual Fields ONrmal	Abnormal							
Has the applicant had refractive surgery? OYes No										
Colour Perception Examination		I	-							
Pseudoisochromatic Plates Type Number of plates Number of errors										
HEARING EXAMINATION		udiogram / Audioscope (if appl								
Does the applicant pass the Right OYes No	HZ 500	1000 2000	3000 4000							
whispered voice test at 2m (6ft)?	Right									
Left ()Yes ()No	Left									
26-0010E (1901-06)										
26-0010E (1901-06)Page 2 of 3Additional space for comments is available on page 3										

## PROTECTED "B" WHEN COMPLETED

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

CAME Stamp

Date (yyyy-mm-dd)

Signature

