Dr Brandon Head
Together, Your Health

Dr Brandon Head
PostNet Suite 492
Private Bag X26
Sunninghill
2157

Practice Number: 1456199

Required documentation and information for an Aviation Medical (All Classes)

Please ensure you bring the following to the medical assessment:

- Proof of identity in the form of either your:
  - SA identity document or
  - Passport
- Produce for inspection any license held for which the certificate is required
- Provide the most recently held certificate, if any
- Your ***total number*** of hours flying time and number of hours flown ***since*** the previous medical
- Completed forms to be email back to us (reception@drbrandonhead.joburg) at least 24 hours prior to the medical assessment. These include:
  - Aviation Medical Report CA 67-2(a)
  - Aviation Medical Mental Screening Questionnaire CA 67-08
- A comprehensive list of any current chronic medication
- A list of any medication you use on a regular basis. This should include over the counter medication, homeopathic medication, multivitamins and supplements
- All spectacles, as these are required during your eye test as part of the medical examination:
  - Reading spectacles
  - Bifocals/Multifocal's
  - Distance spectacles
  - A letter from your optometrist stating the prescription for your spectacles
  - ***Your eye test and therefore aviation medical cannot be completed without your spectacles***
- Any relevant medical reports
- **Chest X-Ray** for all ***initial medicals*** and certain follow up assessments - **email the report to us prior to assessment (**reception@drbrandonhead.joburg**)**
- ***If*** you are required to do an exercise ECG (you will be notified prior to the assessment) you should bring/ wear running shoes and clothing suitable for a treadmill test. Changing facilities are available. The need for an exercise ECG is based on age and cardiovascular risk factors.
  After the medical is completed the information is uploaded to the SACAA website. Your Medical Certificate is then printed. This process takes up to 15 minutes after the medical is completed.
  Please allow for a 15 minute wait after you have completed the medical.
- **The certificate cannot be issued if all required documentation and X-rays are not available**.
- **The medical certificate will not be issued you do not meet all the medical requirements.**

Regards

Dr Brandon Head
Senior Aviation Medical Examiner

Diane Watermeyer
Aviation Medical Liaison

SOUTH AFRICAN CIVIL AVIATION AUTHORITY

Section/division **AVMED**
Telephone number: **011-545-1000**
Physical address **Ikhaya Lokundiza, 16 Treur Close, Waterfall Park, Bekker Street, Midrand, Gauteng**
Postal address: **Private Bag X73, Halfway House 1685** *Website:* **www.caa.co.za**

Form Number: CA 67-2(a)

Fax Number:

AVIATION MEDICAL REPORT

PERSONAL INFORMATION

1. Surname		First name(s)	
2. Postal address			
		Postal code	
3. Telephone numbers	During office hours	Cell No.	E-mail
4. Date of birth (dd/mm/yyyy)		5. Nationality	
6.Identity/Passport No.		7. Gender	
8. Occupation		9. Medical Class applied for	
10.Licence Number		11. Licence Type	12.Type of flying Intended: Single-Crew ☐ Multi-crew ☐

Flight time (hours)			**Type of flying intended**			**Previous medical examination**	
Last 6 months	Last 12 months	Total	Recreation	Business	Career	Doctor	Date

13. Have you ever had an aviation Medical Assessment denied, suspended or revoked by any licence authority? If yes Discussed with Medical Examiner.
Yes ☐ **No** ☐ **Date:** **Place:**

Details:

14. Any aircraft /vehicle accident or reported incident since last medical?
Yes ☐ **No** ☐ **Date:** **Place:**

Details:

15. Do you drink alcohol?
Yes ☐ **No** ☐
If yes, state average weekly intake in units:

16. Do you smoke tobacco products?
Never ☐ **Previously** ☐ **Currently** ☐

Date stopped:
State type, amount and number of years:

17 Do you currently use any medication, including non-prescribed medication? *Please attach additional pages if space is insufficient.*

Yes ☐ **No** ☐
If yes, state the name of medication, date commenced, daily or weekly dose, and diagnosis

14. Any limitations on licence / Restrictions?

Yes ☐ **No** ☐

Details:

ID Number/Passport No.		Date	

MEDICAL HISTORY

Do you have, or have you ever had, any of the following? Yes or No must be ticked after each question.

	Y	N		Y	N
1. Eye disorders/eye surgery			19. Psychological / psychiatric trouble of any sort		
2. Spectacles and/or contact lenses ever worn			20. Alcohol/drug/substance abuse		
3. Spectacles/contact lens prescriptions/change since last medical exam			21. Attempted suicide		
4. Hay fever, other allergy			22. Motion sickness requiring medication		
5. Asthma, lung disease			23. Anaemia/Sickle cell trait/other blood disorders		
6. Heart or vascular disease			24. Malaria or other tropical disease		
7.High or low blood pressure			25. A positive HIV test		
8.Kidney stone or blood in urine			26. Sexually transmitted disease		
9. Diabetes, hormone disorder			27. Bleeding from the rectum		
10. Stomach, liver or intestinal trouble			28. Any other illness or injury		
11.Deafness, ear disease			29. Visit to medical practitioner since last medical examination		
12. Admitted to hospital			30. Refusal of life insurance		
13.Nose or throat disease or speech disorder			31. Refusal of issue or revocation of aviation licence		
14.Head injury or concussion			32. Medical rejection from or for military service		
15. Frequent or severe headaches			33. Award of pension or compensation for injury or illness		
16. Dizziness or fainting spells			34. Gynaecological disorder (including menstrual / pregnancy)		
17. Unconsciousness (for any reason)			35.Prostate Problems		
18.Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.			36.Malignant tumour or cancer		

FAMILY HISTORY OF:

	Y	N		Y	N
37. Heart disease			42. Diabetes		
38. High blood pressure			43. Tuberculosis		
39. High cholesterol level			44. Allergy/asthma/eczema		
40.Epilepsy			45. Inherited disorders		
41.Mental illness			46. Glaucoma		

REMARKS

Aviation Medical Examiner to comment in full on all items marked YES. Please attach additional pages if space is insufficient.

NOTICE

Any person who makes, either orally or in writing, a false or misleading statement in or in connection with any application for a licence, certificate or rating issued under these regulations or any return furnished in accordance with any requirement of these regulations, shall be guilty of an offence. (Civil Aviation Regulations (CAR), Part 185.001.1(1)(di-dii)

DECLARATION BY APPLICANT

I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete and correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statement in connection with this application, or if I do not consent to release the support the supporting medical information, the Authority may refuse to grant me Medical Assessment or may withdraw any Medical Assessment granted, without prejudice to any other legal action applicable pursuant .

Consent to release of medical information: I hereby give my consent that all relevant medical information may be released and submitted to the Medical Assessor of the Licensing Authority. **Note**: Medical Confidentiality will be respected all times

SIGNATURE OF APPLICANT	**NAME IN BLOCK LETTERS**	**DATE**
SIGNATURE OF AME (AS WITNESS)	**NAME IN BLOCK LETTERS**	**DATE**

ID Number/Passport No.		Date	

SOUTH AFRICAN CIVIL AVIATION AUTHORITY

Section/division **Aviation Medicine**
Telephone number: **011-545-1000**
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Form Number: CA 67-08

AVIATION MENTAL SCREENING QUESTIONNAIRE

1.	**PERSONAL INFORMATION**			
1.1.	Surname			
1.2.	First name(s)			
2.	**SUGGESTED QUESTIONS FOR DEPRESSION**			
2.1.	Do you have, or have you ever had, any of the following? Yes or No must be ticked after each question.		**YES**	**NO**
2.1.1.	During the past three months, have you often been bothered by feeling down, depressed, or hopeless?			
2.1.2.	During the past three months, have you often been bothered by having little interest or pleasure in doing things?			
2.1.3.	During the past three months, have you been bothered by having problems falling asleep, staying asleep, or sleeping too much, that is unrelated to sleep disruption from night flying or trans meridian operations?			
2.1.4.	In the past three months, has there been a marked elevation in your mood lasting for more than one week?			
2.1.5.	Other, please specify in detail:			
3.	***SUGGESTED QUESTIONS FOR ANXIETY/PANIC ATTACK***		**YES**	**NO**
3.1.	In the past three months, have you had an episode of feeling sudden anxiety, fearfulness, or uneasiness?			
3.2.	In the past three months, have you experienced sensations of shortness of breath, palpitations (racing heartbeat) or shaking while at rest without reasonable cause?			
3.3.	In the past year have you needed to seek urgent medical advice because of anxiety?			
4.	**SUGGESTED QUESTIONS CONCERNING ALCOHOL USE:**		**YES**	**NO**
4.1.	Have you ever felt that you should cut down on your drinking?			
4.2.	Have people annoyed you by criticizing your drinking			
4.3.	Have you ever felt guilty about your drinking?			
4.4.	Have you ever needed a drink first thing in the morning?			
4.5.	How many alcoholic drinks would you have in a typical week?			
4.6.	How many alcoholic drinks would you have on a typical day when you are drinking?			
5.	**SUGGESTED QUESTIONS CONCERNING DRUG USE:**		**YES**	**NO**
5.1.	Have you used drugs other than those required for medical reasons?			
5.2.	Which non-prescription (over the counter) drugs have you used? When did you last use this drug(s)?			
6.	Other -pls provide MIRE information			

Aviation Medical Examiner to comment in full on all items marked YES. Please attach additional pages if space is insufficient & Applicants not required to sign this section

NOTICE

SIGNATURE OF AME	**NAME IN BLOCK LETTERS**	**DATE**

ID Number/Passport No.		Date	