



**Islamic Republic of Afghanistan
Civil Aviation Authority**

AEROMEDICAL FORMS

**AFGHANISTAN CIVIL AVIATION AUTHORITY DIRECTIVE
(ACAF)**

ACAF-PEL-002.0

Personnel Licensing

26 Dec 2014

Revision 0

H.E. Capt. Hamid
Director General
Civil Aviation Authority

Approved: _____



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0 Administration and Control

The following list contains key abbreviations used in this document, as well as others likely to be in common use in the respective area.

0.1 Abbreviations

ACAA	Afghanistan Civil Aviation Authority
ACAD	Afghan Civil Aviation Directives
ACAF	Afghan Civil Aviation Forms
ACAR	Afghan Civil Aviation Regulation
AMA	Aviation Medical Assessor
AME	Aviation Medical Examiner
ATCO	Air Traffic Controller
ATPL	Air Transport Pilots License
ATSEP	Air Traffic Safety Electronics Personnel ?
CPL	Commercial Pilots License
FE	Flight Engineer
PPL	Private Pilot License
SPL	Sport Pilot License



0.2 Record of Revision

The revision page shall be completed to show: revision number, effective date of the revision, description of changes and the responsible person. Revised pages will display the DD MMM YYYY revision date and revision number on the bottom of each page. Any revision shall display the next sequential number.

[illegible]



1 Application Form for a Medical Certificate (O-MED-001)

APPLICATION FORM FOR A MEDICAL CERTIFICATE

Complete this page fully using a black ball point pen in block capitals – Refer to instructions pages for detail					MEDICAL IN CONFIDENCE	
1. Surname:		2. Class of medical certificate applied for 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/>				
3. Forename:		4. Previous surname(s):		5. Application initial <input type="checkbox"/> Renewal/Revalidation <input type="checkbox"/>		
6. Place and country of birth:		7. Date of birth/Age:		8. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		9. Reference number:
10. Nationality:				11. Type of license desired:		
12. Permanent address: Country: Telephone No:		13. Postal address (if different): Country: Telephone No:		14. Occupation (principal):		
				15. Employer:		
				16. Last medical application Date: Place:		
17. Aviation license held (type):		License number:		Country of issue:		18. Any Conditions/Limitations/Variations on the License/Medical certificate No <input type="checkbox"/> Yes <input type="checkbox"/> Details:
19. Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Country: Details:				20. Total flight time (hours)		21. Flight time (hours) since last medical:
				22. Aircraft presently flown:		
23. Any aircraft accident/incident since last medical? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: Country: Details:				24. Type of flying intended:		
				25. Present flying activity Single pilot <input type="checkbox"/> Multi-pilot <input type="checkbox"/>		
26. Do you smoke tobacco? Never <input type="checkbox"/> No <input type="checkbox"/> Date stopped: Yes <input type="checkbox"/> state type and amount:				27. Do you currently use any medication? No <input type="checkbox"/> Yes <input type="checkbox"/> State drug, dose, date started and why		
28. Alcohol-state average weekly intake:						



29. General & Medical History: Do you have or have ever had any of the following? Yes or No (or indicated) must be ticked after each question. Elaborate Yes answers in the remarks section (30):

						FAMILY HISTORY OF:	
	Yes	No		Yes	No		Yes No
1. Eye trouble/Eye operation			12. Nose, throat or speech disorder			23. Malaria or other tropical diseases	33. Heart disease
2. Spectacles & or contact lenses ever worn			13. Head injury or concussion			24. A positive HIV test	34. High blood pressure
3. Spectacles/contact lens prescription/change since last medical exam			14. Frequent or severe headaches			25. Sexually transmitted disease	35. High cholesterol level
4. Hay fever other allergy			15. Dizziness or fainting spells			26. Admission to hospital	36. Epilepsy
5. Asthma, lung disease			16. Unconsciousness for any reason			27. Any other illness or injury	37. Mental illness
6. Heart or vascular trouble			17. Neurological disorders, stroke, epilepsy, seizure, paralysis etc.			28. Visit to medical practitioner since last medical examination	38. Diabetes
7. High or low blood pressure			18. Psychological/psychiatric trouble of any sort			29. Refusal of life insurance	39. Tuberculosis
8. Kidney stone or blood in urine			19. Alcohol/drug/substance abuse			30. Refusal of flying license	40. Allergy/asthma/eczema
9. Diabetes, hormone disorder			20. Attempted suicide			31. Deafness/ear disorder	41. Inherited disorders
10. Stomach, liver or intestinal trouble			21. Motion sickness requiring medication			32. Medical rejection from or for military service	42. Glaucoma
11. Anaemia/Sickle cell trait/Other blood disorders			22. Award of pension or compensation for injury or illness			Female only Gynecological, menstrual problems. Are you pregnant?	Last menstrual period

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

31. **Declaration:** I hereby declare that I have carefully considered the statement made above and to the best of my belief they are complete and correct and that I have not withheld 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 Authority 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. **CONSENT TO RELEASE OF MEDICAL INFORMATION:** I hereby authorize the release of all information contained in this and any or all attachments to the Aeromedical Section and where necessary the Aeromedical section of another State, recognizing that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the Authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times.

Date

Signature of Applicant

Signature of AME (Witness)



2 Medical Certificate (O-MED-002)

MEDICAL CERTIFICATE CLASS

(Pertaining a Flight Crew License)

1. License No: _____
2. Name of Holder: _____
Surname First name
3. Title: _____
4. Place & date of birth: _____
5. Nationality: _____
6. Sex: _____
7. Address: _____

8. Height: _____
9. Weight: _____
10. Color of hair: _____
11. Color of eye: _____
12. Signature of holder: _____
13. Aviation Medical Examiners name: _____
14. Address of AME: _____

15. Date of examination: _____
16. Aeromedical Assessment: FIT/NO FIT for ATPL/CPL/FE/ATCO/PPL/SPL/Cabin Crew License(s):

17. Limitation Restrictions: _____

18. Date of Issue: _____
19. Signature of Aviation Medical Examiner: _____
20.

Date (day/month/year of	Last	Next
Comprehensive Medical Exam		
Medical (General) Exam		
Electrocardiogram (ECG)		
Audiogram		
21. AMME
Stamp and number
22. Assessment is subject to review by the Aeromedical Standards
23. Distribution:
 - I. Holder' copy (white)
 - II. AME's copy (blue)
 - III. Aeromedical Section's copy (yellow)



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3 Otorhinolaryngology Examination Report (O-MED-003)

OTORHINOLARYNGOLOGY EXAMINATION REPORT

Complete this page fully using a black ball point an in block capitals

Applicant's details

MEDICAL IN CONFIDENCE

1. Surname:	2. Class of medical certificate applied for		1 st <input type="checkbox"/>	2 nd <input type="checkbox"/>	3 rd <input type="checkbox"/>
3. Forename:	4. Previous surname(s):		5. Application		
			initial <input type="checkbox"/> Renewal/Revalidation <input type="checkbox"/>		
	6. Date of birth/Age:	7. Sex:	8. Reference number:		
		Male <input type="checkbox"/> Female <input type="checkbox"/>			
<p>(401) Consent to release of medical information: I hereby authorize the release of all information contained in this report and any or all attachments to the Aeromedical Examiner, the Authority and where necessary the Aeromedical Section of another State, recognizing that these documents or any other electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the Authority, providing that I or my physician may have access to them according to national laws. Medical Confidentiality will be respected at all times.</p> <p>Date: _____ Signature of the applicant: _____ Signature of medical examiners (witness): _____</p>					
<p>(402) Examination Category</p> <p>Initial <input type="checkbox"/></p> <p>Extended <input type="checkbox"/></p> <p>Renewal/Reval <input type="checkbox"/></p> <p>Special referral <input type="checkbox"/></p>		<p>(403) Otorhinolaryngology history</p>			

Clinical examination

Check each item		Normal	Abnormal	
(404)	Head, face, neck, scalp			
(405)	Buccal cavity, teeth			
(406)	Pharynx			
(407)	Nasal passages and naso-pharynx (inc.. Anterior rhinoscopy)			
(408)	Vestibular system incl. Romberg test			
(409)	Speech			
(410)	Sinuses			
(411)	Ext. acoustic meati, tympanic membranes			
(412)	Pneumatic otoscopy			
(413)	Impedance tympanometry including valsalva maneuver (initial only)			
Additional testing (if indicated)		Not Performed	Normal	Abnormal
(414)	Speech audiometry			
(415)	Posterior rhinoscopy			
(416)	EOG; spontaneous and positional nystagmus			
(417)	Differential caloric test or vestibular autorotation test			
(418)	Mirror or fibre laryngoscopy			

(421) Otorhinolaryngology remarks and recommendations

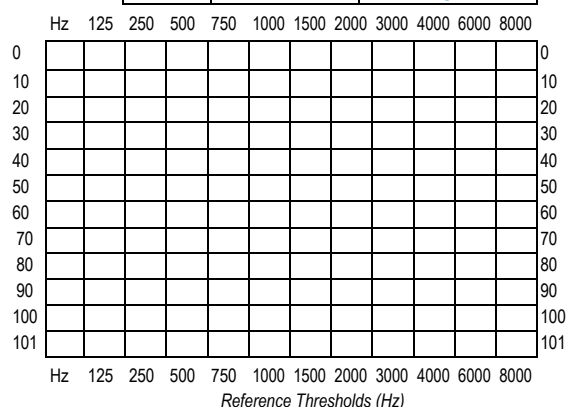
--

(419) Pure tone audiometry dB HL (hearing level)

Hz	Right ear	Left ear
250		
500		
1000		
2000		
3000		
4000		
8000		

(420) Audiogram

TEST	Right ear (Red)	Left ear (Blue)
AIR	—●—●—	—XX—
BONE





(422) 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.

(423) Place and date:	ORL Examiner's Name and Address (Block Capitals)	AME Stamp with No:
Aviation Medical Examiner's Signature	Telephone No: Telefax No:	



4 Medical Examination Report (O-MED-004)

CLINICAL EXAMINATION REPORT

(1) Examination Category	(2) Height	(3) Weight	(4) Eye Color	(5) Hair Color	(6) Blood pressure - seated	(7) Puls-resting	
Initial <input type="checkbox"/>	cm	kg			Systolic	Diastolic	Rate
Renewal/Reval <input type="checkbox"/>	Body Mass Index (BMI) =						Rhythm
Extended <input type="checkbox"/>							

Clinical examination: Check each item

		Normal	Abnormal			Normal	Abnormal
(8)	Head, face, neck, scalp			(18)	Abdomen, hernia, liver, spleen		
(9)	Mouth, throat, teeth			(19)	Anus, rectum		
(10)	Nose, sinuses			(20)	Genito-urinary system		
(11)	Ears, drum, eardrum motility			(21)	Endocrine system		
(12)	Eyes – orbit & adnexa: visual fields			(22)	Upper & lower limbs, joints		
(13)	Eyes – pupils and optic fundi			(23)	Spine, other musculoskeletal		
(14)	Eyes – ocular motility: nystagmus			(24)	Neurologic – reflexes, etc.		
(15)	Lungs, chest, breasts			(25)	Psychiatric		
(16)	Heart			(26)	Skin, identifying marks and lymphatics		
(17)	Vascular system			(27)	General systemic		
(28)	NOTES: Describe every abnormal finding. Enter applicable item number before each comment Use spare sheet if space is inadequate.						

Psychometric tests: Yes ☐ No ☐ Date

Visual acuity

(29) Distant vision of 5m/6m Spectacles Contact lenses

Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		

(30) Intermediate vision Uncorrected Corrected

N14 at 100 cm	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(31) Near vision Uncorrected Corrected

N5 at 30 – 50 cm	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(35) Pulmonary function

Peak Expiratory Flow L/min
Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

(36) Hemoglobin

g/dl
Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

Accompanying Reports Not performed Normal Abnormal

(37) ECG	
(38) Audiogram	
(39) Ophthalmology	
(40) ORL (ENT)	
(41) Chest X-ray	
(42) Blood lipids	
(43) Pulmonary function	
(44) EEG	
(45) Others (No)	



<p>(32) Spectacles</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Yes <input type="checkbox"/></td> <td style="width: 50%;">No <input type="checkbox"/></td> </tr> </table>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<p>(44) Contact lenses</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Yes <input type="checkbox"/></td> <td style="width: 50%;">No <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Type</td> </tr> </table>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type		<p>(46) Aviation medical examiner's recommendations:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%;"> Name of applicant: <input type="checkbox"/> Fit class <input type="checkbox"/> Medical certificate issued class: <input type="checkbox"/> Unfit class <input type="checkbox"/> Deferred for further evaluation? If yes, why and to whom? </td> </tr> </table>	Name of applicant: <input type="checkbox"/> Fit class <input type="checkbox"/> Medical certificate issued class: <input type="checkbox"/> Unfit class <input type="checkbox"/> Deferred for further evaluation? If yes, why and to whom?		
Yes <input type="checkbox"/>	No <input type="checkbox"/>										
Yes <input type="checkbox"/>	No <input type="checkbox"/>										
Type											
Name of applicant: <input type="checkbox"/> Fit class <input type="checkbox"/> Medical certificate issued class: <input type="checkbox"/> Unfit class <input type="checkbox"/> Deferred for further evaluation? If yes, why and to whom?											
<p>(33) Hearing</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 20%;">Right ear</th> <th style="width: 20%;">Left ear</th> </tr> </thead> <tbody> <tr> <td>Conventional voice test at 2m back turned to examiner</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Forced at 6 m whisper</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </tbody> </table>		Right ear	Left ear	Conventional voice test at 2m back turned to examiner	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Forced at 6 m whisper	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Right ear	Left ear									
Conventional voice test at 2m back turned to examiner	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>									
Forced at 6 m whisper	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>									
<p>(34) Urinalysis</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 15%;">Normal</th> <th style="width: 15%;">Abnormal</th> </tr> </thead> <tbody> <tr> <td>Glucose</td> <td>Protein</td> <td>Blood Others</td> </tr> </tbody> </table>		Normal	Abnormal	Glucose	Protein	Blood Others					
	Normal	Abnormal									
Glucose	Protein	Blood Others									

<p>(47) Comments, restriction, limitations</p>
--

<p>(48) Medical examiner's declaration</p> <p>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.</p>		
<p>(49) Place and date:</p>	<p>Examiner's name and address (Block capitals)</p>	<p>AME Stamp with AME No:</p>
<p>Aviation Medical Examiner's Signature</p>	<p>Telephone No: Telefax No:</p>	



5 Ophthalmology Examination Report (O-MED-005)

OPHTHALMOLOGY EXAMINATION REPORT

Complete this page fully using a black ball point an in block capitals

Applicant's details

MEDICAL IN CONFIDENCE

1. Surname:	2. Class of medical certificate applied for	1 st <input type="checkbox"/>	2 nd <input type="checkbox"/>	3 rd <input type="checkbox"/>
3. Forename:	4. Previous surname(s):	5. Application initial <input type="checkbox"/> Renewal/Revalidation <input type="checkbox"/>		
	6. Date of birth/Age:	7. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	8. Reference number:	
	(10) Nationality		(11) Type of license desired:	
(301) Consent to release of medical information: I hereby authorize the release of all information contained in this report and any or all attachments to the Aeromedical Examiner, the Authority and where the Aeromedical Section of another State, recognizing that these documents or any other electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the Authority, providing that I or my physician may have access to them according to national laws. Medical Confidentiality will be respected at all times.				
Date: _____ Signature of the applicant: _____ Signature of medical examiners (witness): _____				
(302) Examination Category Initial <input type="checkbox"/> Extended <input type="checkbox"/> Renewal/Reval <input type="checkbox"/> Special referral <input type="checkbox"/>	(303) Ophthalmology history			

Clinical examination

Check each item	Normal	Abnormal
(304) Eyes, External & Eyelids		
(305) Eyes Exterior (Slit lamp. oph.)		
(306) Eye position and movements		
(307) Visual fields (confrontation)		
(308) Pupillary reflexes		
(309) Fundi (Ophthalmoscopy)		
(310) Convergence Cm		
(311) Accommodation D		
(312) Ocular muscle balance (in prism diopters)		
Distant a 5/6	Near at 30-50cm	
Ortho	Ortho	
Eso	Eso	
Hyper	Hyper	
Cyclo	Cyclo	
Tropia Yes <input type="checkbox"/> No <input type="checkbox"/>	Phoria Yes <input type="checkbox"/> No <input type="checkbox"/>	
Fusional reserve testing		
Not performing <input type="checkbox"/>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>
(313) Color perception		
Pseudo-Isochromatic plates	Type:	
No of plates:	No of errors:	
Advanced color perception indicated	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Method:		
Color SAFE <input type="checkbox"/>	Color UNSAFE <input type="checkbox"/>	

Visual acuity

(314) Distant vision at 5m/6m	Spectacles	Contact lenses	
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		
(315) Intermediate vision at 1 m	Spectacles	Contact lenses	
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		
(316) Near vision at 30-50cm	Spectacles	Contact lenses	
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		
(317) Refraction	Sph	Cylinder	Axis
Right eye			
Left eye			
Actual refraction examined <input type="checkbox"/>	Spectacles prescription based <input type="checkbox"/>		
(318) Spectacles	(319) Contact lens		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Type:	Type:		
(320) Intra-ocular pressure			
Right	Left (mmHg)		
Method: Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>		

(321) Ophthalmological remarks and recommendation

(322) Examiners 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.-

(323) Place and date:	Oph. Examiner's name and address: (Block capitals)	AME Stamp with No:
Aviation Medical Examiner's Signature:	Telephone No:	
	Telefax No:	



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6 Protocol for Alcohol/Psychoactive Substances Assessment (O-MED-006)

PROTOCOL FOR ALCOHOL/PSYCHOACTIVE SUBSTANCES ASSESSMENT

1. Inform Captain/ATCO in-charge about impending procedure.
2. Show Captain/ATCO the relevant sections of the ACARs 1.2.1.8 which is on a laminated separate sheet indicating the sanctions for refusal to test and positivity for alcohol and or psychoactive substances.
 - 2.1 Aircrew or ATCO selected for spot check
 - 2.2 Refusal of an aircrew or ATCO to be tested for alcohol or psychoactive substances carries an immediate penalty of one year suspension from aircrew or ATCO duties.
3. Commence spot check.
4. If test is **negative** aircrew/ATCO is **immediately allowed to continue** with his/her duties.
5. If found **positive** for alcohol or drugs the aircrew or ATCO will be **immediately taken off the flight or traffic control** for further administrative, disciplinary measures, and aeromedical disposition
6. The positive test sample is sent to a reference laboratory for confirmatory testing.



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7 Alcohol/Psychoactive Substances Assessment Procedure Form (O-MED-007)

ALCOHOL/PSYCHOACTIVE SUBSTANCES ASSESSMENT PROCEDURE

1. Name of Airline or Organization: _____
2. Name of most senior aircrew/ATCO on duty acknowledging procedure:
 - 2.1 Full Name: Surname First Middle

 - 2.2 Designation: _____
 - 2.3 Signature/Date: _____
3. Location of spot check: _____
 - 3.1 Date: _____
 - 3.2 Time of spot check commencement: _____
4. Candidate selected for spot check:
 - 4.1 Full Name: Surname First Middle

 - 4.2 Designation: _____
 - 4.3 Pre-Test Signature/Date: _____
 - 4.4 License No: _____
 - 4.5 Expiration Date: _____
5. Type of drug tested for: _____
 - 5.1 Sample used: Air (Breathe) Blood Urine

 - 5.2 Equipment used: _____
 - 5.3 Test result: Positive Negative
 - 5.4 Test value of alcohol or psychoactive substance: _____
 - 5.5 Test of spot check conclusion: _____
 - 5.6 Post test Signature/Date: _____
6. Positive Result:
 - 6.1 Test repeated
 - 6.2 Second test result: Positive Negative
 - 6.3 Test value of alcohol or psychoactive substance: _____
 - 6.4 Time of second test conclusion: _____



6.5 Second test sample if blood or urine taken in a tamper proof container marked, sealed in the presence of the positive aircrew/ATCO.

6.6 Proceed if desired by the aircrew/ATCO to the confirmatory laboratory accompanied by the representative of the ACAA for confirmatory testing.

AEROMEDICCAL STANDARDS USE ONLY

6.7 Comments/Recommendations/Aeromedical Disposition: _____

6.8 Final Decision: _____

6.9 Name(s) of Medical Assessor(s)/Inspector(s):

6.9.1 _____

6.9.2 _____

6.9.3 _____

6.10 Signature(s) of Medical Assessor(s)/Inspector(s):

6.10.1 _____

6.10.2 _____

6.10.3 _____

6.11 Date: _____



8 Alcohol Testing Form (O-MED-008)

(The instruction for completing this form are on the back of the form)

STEP 1: TO BE COMPLETED BY THE AEROMEDICAL ASSESSOR

- A: Aircrew or ATCO Name _____
(Print) (First, M.I., Last))
- B: Aircrew or ATCO Employee ID No _____
- C: Employer Name _____
Street _____
City, State _____
Employers Representative: _____
Name Phone Number
- D: Reason for Test:
☐ Random ☐ Post-Accident ☐ Return to Duty ☐ Follow up ☐ Pre-employment
☐ Reasonable suspicion/cause

STEP 2: TO BE COMPLETED BY AIRCREW OR ATCO

I certify that I am about to submit to alcohol testing required by Authority and the Afghanistan Civil Aviation Regulations and that the identifying information provided on the form is true and correct.

Signature of Aircrew/ATCO _____ Date (Month/Day/Year) _____

STEP 3: TO BE COMPLETED BY THE AEROMEDICAL ASSESSOR

I certify that I am about to submit to alcohol testing on the above named individual in accordance with the procedure established in the Aeromedical Technical Guidance Material and the ACARs, that I am qualified to operate the testing device(s) identified, and that the results are as recorded.

Aeromedical Assessor: ☐ BAT ☐ STT ☐ Device: ☐ Saliva ☐ Breathe
15-Minute-Wait ☐ Yes ☐ No

Screening Test: (For Breath Device write in the space below only if the testing device is not designed to print)

Conformation Test: Results must be affixed to each copy of this form or printed directly onto the form.

REMARKS

Afghanistan Civil Aviation Authority

Aeromedical Assessor's Name (First, M.I., Last) _____ City, State _____

Phone Number _____

Signature of Aeromedical Assessor _____ Date (Month/Day/Year) _____

STEP 4: TO BE COMPLETED BY AIRCREW OR ATCO

I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are 0.02 or greater.

Signature of Aircrew/ATCO _____ Date (Month/Day/Year) _____

Affix or Print
Additional Test Results here

Affix with Tamper
Evident Tape

Affix or Print
Additional Test Results here

Affix with Tamper
Evident Tape

Affix or Print
Additional Test Results here

Affix with Tamper
Evident Tape

Copy 1 – Original – Forward to the Employer

**Instructions for Completing the ACAA Alcohol Testing Form**

Note: Use a ballpoint pen, press hard, and check all copies for legibility.

STEP 1:

The Aeromedical Assessor of the ACAA completes the information required in this step. Be sure to print the Aircrew or ATCO's name and check the box identifying the reason for the test.

Note: If the Aircrew or ATCO refuses to provide SSN or ID number, be sure to indicate this in the remarks section in STEP 3. Proceed with STEP 2.

STEP 2:

Instruct the Aircrew or ATCO to read, sign and date the Aircrew or ATCO certification statement in STEP 2.

Note: If the Aircrew or ATCO refuses to sign the certification statement, do not proceed with the alcohol test. Contact the designated employer representative.

STEP 3:

Aeromedical Assessor completes the information required in this step and checks the type of device (saliva or breath) being used. After conducting the alcohol screening test, do the following (as appropriate):

Enter the information for the screening test (test number, testing device name, testing device serial number or lot number and expiration date, time of test with any device dependent activation times, and the results), on the front of the ATF. For a breath testing device capable of printing, the information may be part of the printed record.

Note: Be sure to enter the result of the test exactly as it is indicated on the breath testing device e.g. 0.00, 0.02, 0.02, etc.

Affix the printed information in the space provided, in a tamper-evident manner (e.g. tape), or the device may print the results directly on the ATF. If the results of the screening test are less than 0.02, print, sign your name, and enter today's date in the space provided. The test process is complete.

If the results of the screening test are 0.02 or greater, a confirmation test must be administered in accordance with ACARs. An Evidential Breath Testing device that is capable of printing confirmation test information must be used in conducting this test.

After conduction the alcohol confirmation test, affix the printed information in the space provided, in a tamper-evident manner (e.g. tape), or the device may print the results directly on the ATF print, sign your name, and enter the date in the space provided. Go to STEP 4.

STEP 4:

If the Aircrew or ATCO has a breath alcohol confirmation test result of 0.02 or higher, instruct the Aircrew or ATCO to read, sign and date the Aircrew or ATCO certification statement in STEP 4.

Note: If the Aircrew or ATCO refuses to sign the certification statement in STEP 4, be sure to indicate this in the remarks line in STEP 3.

Immediately notify the DER if the Aircrew or ATCO has a breath alcohol confirmation test result of 0.02 or higher.

Forward Copy 1 to the employer. Give Copy 2 to the Aircrew or ATCO. Retain Copy 3 for BAT/STT records.

**9 Application Form for Appointment as an Aviation Medical Examiner (AME) (O-MED-009)****APPLICATION FORM FOR APPOINTMENTS AS
AN AVIATION MEDICAL EXAMINER (AME)**

*Attach 2
Passport
Photographs
Here*

Please complete in block capitals by own handwriting

1. Surname: _____
2. Forenames: _____
3. Place and date of birth: _____
4. Medical specialty: _____
5. Any aviation medicine qualifications: _____

6. Address (where Aircrew Examinations will be performed):

7. Office Telephone/Fax No. and E-mail: _____

8. Home Address & Telephone No:

9. Nationality:

10. Date & Type of Registration with which Medical Council:

11. Any designation as Civil Aviation Medical Examiner to other CAA's:
(If yes, please state and submit proof)



12. Professional Training (University; Year of Graduation & Degree Awarded):

13. Appointments & Professional Duties (Dates & Addresses/Locations):

14. Experience (Type of practice, No. of years in practice & Addresses/Locations):

15. Civil Aviation Experience:

Please provide details if any flying training

Type of Aviation License _____

Place of issue _____

Type of aircraft & total flying hours

16. Provide Records of ACAA AMEs Seminars Attended:

17. Record of Military Aviation Medicine Qualifications & Experience:

18. Member of Medical/Aeromedical Associations or Societies:

Attach photocopies of relevant documents/certificates.

**Declaration**

I hereby declare that the information provided on this application form and in the attachments/ documents forwarded by me is correct to the best of my knowledge and belief, and I agree to the conditions for acceptance as AME which accompanies this application. I further agree that all necessary equipment and materials will be acquired upon acceptance as AME and prior to any conduct of ACAA Medical Assessments by me.

19. Date: _____

20. Name & Signature: _____

Note: Please forward completed application form to the head, Aeromedical Standards
Afghanistan Civil Aviation Authority,

(ADDRESS)

Official Use Only:

AME Stamp (No Allocated & Date)

Decisions & Reasons

Signature of Aeromedical Assessor

Date



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**10 Employee Authorization Form
(O-MED-010)**

Employee's Name:	Employee Number:	Company/Location
Supervisor's Name:	Supervisor's Phone No.:	

Reason: ☐ For Cause ☐ Pre-employment ☐ Random ☐ Post-accident**Employee's Consent to Physical Examination/Testing for Controlled Substances
(Drugs) and/or Alcohol/Laboratory Investigations**

I hereby voluntarily consent to a physical examination and tests to be conducted by ACAA physicians. I specifically voluntarily consent to the taking of samples of my urine, breath and/or any other samples for testing to determine the presence of controlled substances (drugs) and/or alcohol and for laboratory investigations related to use of these substances in my system. I voluntarily authorize the release of medical information concerning the results of my physical examination and the tests to the ACAA who will use it to determine if I am in compliance with ACAA regulations and policies on controlled substances (drugs) and alcohol. I understand that I am entitled to a copy of this authorization.

I understand that refusal by me to sign this consent will be cause for disciplinary action, including withdrawal of Aircrew or ATCO medical certificate by the ACAA.

This authorization shall remain valid for a period of 30 days from the date below.

Employee's Name & Signature	Aeromedical Assessor's Name & Signature	Witness Name & Signature
Date	Date	Date

Employee's Statement to decline to Examination and Testing

I decline to authorize the ACAA to perform a physical examination and tests for controlled substances (drugs) and /or alcohol and to release the results to company management.

I also understand that refusal by me to sign this consent will be cause for disciplinary action, including withdrawal of Aircrew or ATCO medical certificate by the ACAA.

Employee's Name & Signature	Date
-----------------------------	------



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11 Drug and Alcohol Declaration Form (O-MED-011)

Declaration

(Confidential (when completed))

Name/License No.: _____ has been

Employed during the preceding three month as:

1. Pilot-in-command ☐ 2. Co-pilot ☐ 3. Flight engineer ☐ 4. Cabin crew ☐

Have there been episodes during the last three month which can be related to drug/alcohol use

☐ Yes ☐ No

How many sick days has the person had during the last three month?

_____ days

How many times has the person been absent because of sickness during the last three month?

_____ times

Has the person performed satisfactorily at Periodic Flight Training/Line Checks/revision courses, etc.?

☐ Yes ☐ No

Comments, if any:

Name: _____

License No.: _____

Signature: _____ Date: _____

Airline/Company: _____



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12 AME Error Generation Form (O-MED-012)

AME ERROR GENERATION FORM

Name of Aircrew:

License No.:

AME Name & Number					Date of Medical	
1)	Types of Errors					
(A)	Form Filling	Total No of fields	No. of Errors	Detail(s) of Error(s)		Error Rating
i)	Application Form e.g. License Number omission	31				
ii)	Medical Examination Report e.g. Peak Expiratory flow result omission	49				
iii)	Otorhinolaryngology Report e.g. comments not given on Audiogram	31				
iv)	Ophthalmology Report e.g. omission of value for intermediate vision	34				
v)	Medical Certificate e.g. omission of date of last and next medical	21				
vi)	Others					
	Total Number of Errors:					
(B)	Medical Examination Reporting		No. of Errors	Detail(s) of Error(s)		Error Rating
	e.g. Lack of comments on aircrew/ATCO's with medical conditions					
(C)	Submission of completed Aircrew medical report to the Authority by AME	5 working days or less		More than 5 working days but less than 2 weeks	More than 2 weeks	Error Rating
2)	Official Remarks:					
3)	Date & Signature of Medical Assessor:					



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13 Medical Assessor's Form (O-MED-013)

MEDICAL ASSESSOR'S REPORT		
1	Type of medical assessment	<input type="checkbox"/> Initial <input type="checkbox"/> Renewal/Revalidation
2	License type	<input type="checkbox"/> ATPL <input type="checkbox"/> SPL <input type="checkbox"/> ATCO <input type="checkbox"/> Flight Engineer <input type="checkbox"/> CPL <input type="checkbox"/> PPL <input type="checkbox"/> Cabin Crew <input type="checkbox"/> ATSEP <input type="checkbox"/> Other
3	License number	
4	Date of medical	
5	Limitations	
6	Medical Assessor's comments	
7	Follow up plan	
8	Aeromedical disposition	<input type="checkbox"/> Fit <input type="checkbox"/> Not Fit <input type="checkbox"/> Pending
Medical Assessor's Signature		Date

Return all completed forms to the head, Aeromedical Section ACAA (Address....)



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14 ACAAC Drug Testing Custody and Control Form (O-MED-014)

ACAAC DRUG TESTING CUSTODY AND CONTROL FORM			
Step 1: Completed by Collector or Employer Representative			
A. Employer Name, Address, ID No: _____			
B. Aeromedical Assessor Name, Address, Phone and Fax No. _____			
C. Employee ID No: _____			
D. Reason for Test: <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post accident <input type="checkbox"/> Return to duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____			
E. Drug test to be performed: <input type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC only <input type="checkbox"/> Other (specify) _____			
F. Collection Site Address: _____ Collector Phone No.: _____ Collector Fax No.: _____			
Step 2: Completed by Collector			
Read specimen temperature within 4 minutes. Is temperature between 90 and 100 F? <input type="checkbox"/> Yes <input type="checkbox"/> No, enter remark _____		Specimen Collection <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided (enter remark) _____	
<input type="checkbox"/> Observed (enter remark) _____			
Remarks: _____			
Step 3: Collector affixes bottle seal(s). Collector dates seal(s). Donor initials seal(s). Donor completes Step 5 on Copy 2 (MRO Copy)			
Step 4: Chain of Custody – Initiated by Collector and completed by Laboratory			
I certify that the specimen given to me by the donor identified in the certification section on copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements .			
Signature of Collector _____		Time of Collection: <input style="width: 100px;" type="text"/>	
(Print) Collector's name (First, MI, Last) _____		Date (Mo/Day/Year) _____	
		Specimen Bottle(s) released to: Name of courier service _____ Other _____	
Received at LAB		Primary Specimen Bottle Seal Intact	
Signature of Accessioner _____		Specimen Bottle(s) released to:	
(Print) Accessioner's name (First, MI, Last) _____		Date (Mo/Day/Year) _____	
Step 5: Completed by Donor			
I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.			
Signature of Donor _____		(Print) Donor's name (First, MI, Last) _____	
Date (Mo/Day/Year) _____			
Phone No: _____ Date of Birth: _____			
Should the results of the laboratory tests for the specimen identified by this form be confirmed positive, the Medical Review Officer will contact you to ask about prescriptions and over-the counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records.			
This list is not necessary. If you chose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). Do not provide this information on the back of any other of the form. Take copy 5 with you.			
Step 6: Completed by Medical Review Officer –Primary Specimen			
In accordance with applicable ACAAC requirements, my determination/verification is: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Test cancelled <input type="checkbox"/> Refusal to test because <input type="checkbox"/> Dilute <input type="checkbox"/> Adulterated <input type="checkbox"/> Substituted			
Remarks: _____			
Signature of Medical Review Officer _____		(Print) Medical Review Officer's name (First, MI, Last) _____	
Date (Mo/Day/Year) _____			
Step 7: Completed by Medical Review Officer – Split Specimen			
In accordance with applicable ACAAC requirements, my determination/verification for the split specimen (if tested) is: <input type="checkbox"/> Reconfirmed <input type="checkbox"/> Failed to reconfirm – Reason: _____			
Signature of Medical Review Officer _____		(Print) Medical Review Officer's name (First, MI, Last) _____	
Date (Mo/Day/Year) _____			



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15 Notification of Denial of Medical Certificate (O-MED-015)

NOTIFICATION OF DENIAL OF MEDICAL CERTIFICATION

Surname:	Date of Birth:	ACAA Ref:
Forename:		
Address:		
Medical Examination date:		
Class of Medical Certificate denied:		
Disqualifying conditions:		
<p>Assessment of your application form & medical examination of above date reveals that you do not meet the ACAA requirements for a medical certificate, (class as above) is hereby denied.</p> <p>You may, if you wish apply to have this decision reviewed. You should apply in writing to the Director Aeromedical Services, Afghanistan Civil Aviation Authority, (ADDRESS)</p>		
Also, this assessment of being below the medical requirements for a medical certificate (class as above) precludes you from the privileges of your license or related ratings with immediate effect.		

AME's use only	DAMS Signature:	AME Signature:
Neoplasm		
Orthopedic		
Dermatological		
Musculoskeletal/ Connective issue		
Hematology	Comments	Date:
Hepatic		AME Stamp:
Neurological		
Respiratory		
Ophthalmological		
Infectious/parasitic		
Cardiovascular		
Immunology		

Copy forwarded to ACAA, on _____ **ACAA MED 127010102**

Aeromedical Policy and Procedure Manual/ Inspectors Handbook	Revision XX
Electronic file name: XXXXXXXXX.doc	Created on XX/XX/XX
	Amended on XX/XX/XX



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16 Medical Certificate Limitations, Conditions and Variations

Code	Limitation, Conditions, Variations	Imposed by	Removed by
TML	Valid only formonth	AME/ACAA	ACAA
VDL	Shall wear corrective lenses and carry a spare set of spectacles	AME/ACAA	ACAA
VML	Shall wear multifocal lenses and carry a spare set of spectacles	AME/ACAA	ACAA
VNL	Shall have available corrective spectacles for near vision and carry a spare set of spectacles	AME/ACAA	ACAA
VCL	Valid by day only	ACAA	ACAA
OML	Valid only as or with qualified co-pilot	ACAA	ACAA
OCL	Valid only as co-pilot	ACAA	ACAA
OSL	Valid only with safety pilot and in aircraft with dual controls	ACAA	ACAA
OAL	Restricted to demonstrated aircraft type	ACAA	ACAA
OPL	Valid only without passengers	ACAA	ACAA
APL	Valid only with approved prosthesis	ACAA	ACAA
AHL	Valid only with approved hand controls	ACAA	ACAA
AGL	Valid only with approved eye protection	ACAA	ACAA
SSL	(Special restrictions as specified)	ACAA	ACAA
SIC	Special instructions – Contact AMS	ACAA	ACAA
AMS	Recertification or renewal only by AMS	ACAA	ACAA
RXO	Requires specialist ophthalmological examinations	AME/ACAA	ACAA



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17 ACAA Aviation Medical Examiners

S/N	AME NO	NAME OF AME/ADDRESS	TELEPHONE FAX	E-MAIL	CLASSES OF EXAMINATION
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
...					

CLASS 1 = ATPL, CPL
CLASS 2 = FE, PPL, SPL, Cabin Crew
CLASS 3 = ATCO



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