Annex IV to ED Decision 2025/002/R

‘AMC and GM to Part-ARA — Issue 1, Amendment 13’

The text of the amendment is arranged to show deleted, new and unchanged text as follows:

— deleted text is ~~struck through~~;

— new or amended text is highlighted in blue;

— an ellipsis ‘[…]’ indicates that the rest of the text is unchanged.

Note to the reader

In amended, and in particular in existing (that is, unchanged) text, ‘Agency’ *is used interchangeably with* ‘EASA’. *The interchangeable use of these two terms is more apparent in the consolidated versions. Therefore, please note that both terms refer to the* ‘European Union Aviation Safety Agency (EASA)’.

The Annex to Decision 2012/016/R of the Executive Director of the Agency of 19 April 2012 is amended as follows:

AMC1 ARA.FCL.200(a)(1) ~~Remark on the licence~~ Procedure for issue, revalidation or renewal of a licence, rating or certificate

REMARK ON THE LICENCE

[…]

Rationale	*RMT.0587*
Update of the title.	

GM1 ARA.FCL.200 Procedure for issue, revalidation or renewal of a licence, rating or certificate

LICENCE ENDORSEMENTS

(a) General

This GM provides guidance on how to make endorsements in pilot licences, in accordance with the applicable requirements of Annex I (Part-FCL) and following the licence format set out in Appendix I to Annex VI (Part-ARA).

(b) Endorsement for licence privileges

For endorsing extra privileges of the holder of a PPL(A) on an MPL in accordance with point FCL.405.A(b)(1) of Part-FCL, the phrase 'PPL(A) privileges included', followed by the date of endorsement of these PPL(A) privileges, should be endorsed in Section XIII ('Remarks') as shown below:

XIII	**Remarks:** PPL(A) privileges included (date of endorsement: DD.MM.YYYY)

(c) *Reserved*

(d) Endorsement for class and type rating privileges

Class and type ratings should be endorsed as set out in the EASA class and type rating endorsement lists, as published on the EASA website. Remarks and restrictions to class and type ratings (relevant line in SECTION XII, page 4 of the licence format) should be endorsed as follows:

Table 1 — Aeroplanes		
Reference	*Requirement*	*Endorsement*
FCL.725(d)(2) Part-FCL Appendix 9, B(5)(j) and (6)(h)	Restriction to multi-pilot operation in a single-pilot aeroplane	MPO only
FCL.720.A(c)	Cruise relief co-pilot restriction	CRCP only
FCL.720.A(d)	OSD restriction to flights with instructor	With instructor only

Table 2 — Helicopters		
Reference	*Requirement*	*Endorsement*
FCL.725(d)(2)	Restriction to multi-pilot operation in a single-pilot helicopter	MPO only
FCL.720.H(b)	Co-pilot restriction for graduates from integrated training with less than 70 hours of PIC experience	Co-pilot only

(e) Endorsements for additional ratings

The night rating as per point FCL.810 is applicable exclusively for holders of an LAPL(A), PPL(A), PPL(H) and PPL(As) and needs to be endorsed solely on these licences. For pilot licences that automatically include NVFR privileges (CPL, MPL, ATPL), there is no need to separately endorse NVFR privileges.

Rationale *RMT.0587*

During several discussions in past EASA Advisory Body meetings, Member States called for guidance material on how to endorse specific privileges and/or limitations on Part-FCL licences, in the context of various requirements of Part-FCL. In this context, this new GM is proposed, addressing some of the most frequently discussed cases of licence endorsements. The intention is to further develop this GM over time with more and more guidance on specific cases, where such need for additional guidance is identified.

In reaction to comments received during the focused consultation with the EASA Advisory Bodies in June 2022, and as a consequence of the major redrafting of point FCL.725 and Part-FCL Appendix 9 in the context of licensing arrangements for single-pilot and multi-pilot operation (SPO and MPO) in single-pilot aircraft, the GM is significantly redrafted. Since the new content of points FCL.725(d) and (da) as well as Part-FCL Appendix 9 in most cases no longer provides for a licence endorsement for SPO

or MPO privileges, the related lines in the draft GM could be removed. For consistency with the aforementioned amendments, the updated draft remains with information on how to endorse the necessary restriction to MPO, in cases where a type rating is initially obtained in MPO only.

In anticipation of future further development of this GM and considering the structure of Part-FCL, point (c) is reserved for future guidance on endorsements for instrument ratings. In reaction to a discussion and subsequent conclusion at the Aircrew TeB meeting on 24 June 2024, point (e) is added for guidance on endorsements for additional ratings, particularly the night rating.

AMC1 ARA.FCL.200(a)(2) ~~ICAO attachment~~ Procedure for issue, revalidation or renewal of a licence, rating or certificate

ICAO ATTACHMENT

The ~~format~~ layout of the ICAO attachment in electronic or paper format is the following:

EASA
European Union Aviation Safety Agency

EUROPEAN UNION **ICAO attachment to automatically validate licences** **(Issue 1)** **issued in accordance with ~~Annex VII to~~ Commission Regulation (EU) No 1178/2011**
1. The licence is automatically validated by all the ICAO Contracting States listed in point (2) under an agreement registered with ICAO. The ICAO Registration Numbers are ~~is~~: ~~XXXX~~ **— 5950 (EU)** **— 5951 (EU plus Switzerland); and** **— 5952 (EU plus Norway and Iceland).**
2. The ICAO Contracting States that automatically validate this licence are: **[Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, ~~Liechtenstein,~~ Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, ~~United Kingdom~~.]~~*~~** *** Please select the applicable ICAO Contracting State(s)**
[Competent authority] **European Aviation Safety Agency** **Date of issue: _____**

EASA Form 207 – Issue 1

Rationale *RMT.0587*

The template as set out with the initial version of this AMC is outdated and needs to be updated, also considering the updated version (Issue 2) which had been published on the EASA website on an interim basis. This AMC amendment:

— reflects the 'interim update' on the EASA website, removing though the reference to the United Kingdom which is no longer an EU Member State;

— replaces the name and stamp of EASA by the name of the competent authority (for consistency, since it is the competent authority that also issues the pilot licence);

— assigns the template with an EASA Form number, re-publishing that template as 'EASA Form 207 – Issue 1' (since it is the first issue of that template under this EASA Form number).

Once the updated AMC is published, the 'interim update' on the EASA website will be deleted.

* Automatic validation of pilot licences - ICAO Registration Numbers Issue 2.pdf (europa.eu)

AMC1 ARA.FCL.300(b) Examination procedures

THEORETICAL KNOWLEDGE EXAMINATIONS FOR PROFESSIONAL LICENCES AND INSTRUMENT RATINGS

[…]

Subject 070 – OPERATIONAL PROCEDURES										
Theoretical knowledge examinations										
Exam length, total number of questions, and distribution of questions										
	ATPL(A)	CPL(A)	ATPL(H)/IR	ATPL(H)	CPL(H)	IR(A) and IR(H)	CB-IR(A)	BIR M01	BIR M02	BIR M03
Time allowed (hours)	1:15	1:00	1:15	1:00	~~0:45~~ 1:00	XX	XX	XX	XX	XX
[…]										

Rationale *RMT.0587*

With this amendment, an editorial error in ED Decision 2020/018/R is corrected. The exam duration for both ATPL(H) VFR and CPL(H) should be 1 hour since the exam structure is the same.

GM1 ARA.FCL.300(b) Examination procedures

DETAILED THEORETICAL KNOWLEDGE EXAMINATON STRUCTURE FOR THE BIR

The tables below provide a detailed structure for the examination papers for the BIR theoretical knowledge examination, based on the relevant content of AMC1 ARA.FCL.300(b) and AMC2 ARA.FCL.300(b), and the detailed syllabus set out in AMC1 FCL.310; FCL.515(b); FCL.615(b); FCL.835(d). Each of the BIR training modules should be examined through one examination paper. The tables indicate the allocation of Subject / topic elements to the examination papers, and how much time should be allocated to the Subject / topic elements within each examination paper. Subject 050 has elements in all three examination papers, Subjects 010, 022 and 033 are split across two examination papers, while Subjects 040, 062 and 090 are covered in one of the examination papers.

Table 1: Module 1 BIR

Subject / topic elements	Number of questions	Time (hours:minutes)
022 02 022 03 022 04 022 13	3 1 3 4	0:20
040 01 040 02 040 03	1 7 8	0:30
050 01 050 02 050 03 050 04 050 05	2 2 1 5 3	0:30
	40	**1:20**

Table 2: Module 2 BIR

Subject / topic elements	Number of questions	Time (hours:minutes)
010 06 010 08 010 09	6 1 2	0:15
033 02	7	0:20
050 10	6	0:15
062 02 062 03 062 06 062 07	6 2 4 7	0:40
	41	**1:30**

Table 3: Module 3 BIR

Subject / topic elements	Number of questions	Time (hours:minutes)
010 05 010 07	2 6	0:15
022 11	1	0:03
033 03 033 04	1 2	0:10

Subject / topic elements	Number of questions	Time (hours:minutes)
033 05	1	
050 06 050 07 050 09	4 1 10	0:30
090 01 090 02 090 03 090 04 090 05 090 06 090 07	2 6 1 2 3 1 1	0:32
	44	**1:30**

Rationale *RMT.0587*

This GM is developed based on repeated requests from Member States, asking for guidance on how to design BIR examination papers related to the BIR training modules, on the basis of the existing ECQB and LO syllabi.

GM2 ARA.FCL.300(b) Examination procedures

CONSIDERATION OF CPL THEORETICAL KNOWLEDGE CREDITS FOR THE BIR EXAMINATION PAPERS

(a) Point FCL.035 and Appendix 1 to Part-FCL establish credits with regard to the theoretical knowledge examinations for applicants for a BIR, when they already hold a CPL(A) or have passed the theoretical knowledge examinations for the CPL(A). In the case of applicants for a BIR who have passed the relevant theoretical knowledge examinations for a CPL(A), Appendix 1 to Part-FCL includes credits for Subjects 040 Human Performance, 050 Meteorology, and 090 Communication. With regard to the latter, point FCL.035(b)(6) includes specific crediting arrangements for cases where applicants, prior to the introduction of Subject 090 Communication, have completed either Subject 091 VFR Communication or Subject 092 IFR Communication (refer to GM1 FCL.035(b)(6)(ii) for related guidance).

(b) Competent authorities should determine the areas of theoretical knowledge for which these applicants will need to take theoretical knowledge examinations. For that purpose, and for designing BIR examination papers that consider specific credits to be granted to individual applicants, competent authorities can use the tables set out in GM1 ARA.FCL.300(b).

Rationale *RMT.0587*

This GM is developed based on repeated requests from Member States, asking for guidance on how to apply provisions on crediting of theoretical knowledge between the theoretical knowledge examinations for the BIR (organised in 'modules') and the theoretical knowledge examinations for the CPL or IR (organised in the conventional 'subjects').

AMC3 ARA.FSTD.120 Continuation of an FSTD qualification

EXTENDED EVALUATION PERIOD — GENERAL

(a) The competent authority should determine the length of the extended recurrent evaluation period of an FSTD, taking into consideration the information listed in point (a) of AMC2 ORA.FSTD.225(b). The extended evaluation period should be 24 or 36 months.

(b) The extension of the recurrent evaluation period should be driven by a risk-based approach as part of the continuous oversight. As such, the performance of the organisation, as well as the performance of the device, should be monitored.

(c) Once the competent authority has granted an extended recurrent evaluation period, it may plan all subsequent recurrent evaluations of the relevant FSTD with the extended time interval of 24 or 36 months, as applicable, until it decides to revert again to a shorter recurrent evaluation period, should the conditions of point ARA.FSTD.120(c) be no longer fulfilled.

(d) The audit of the management system elements, described in point ARA.FSTD.120(c)(3), may be performed remotely, at the discretion of the competent authority, considering the performance of the organisation.

Rationale *RMT.0587 (ex-RMT.0196)*

AMC3 ARA.FSTD.120 is developed to specify how the extended evaluation period (EEP) rules can be implemented by the competent authority.

In point (a), it is clarified that the competent authority may establish an EEP cycle of 24 or 36 months, based on the information/documentation provided in accordance with point (a) of the new AMC2 ORA.FSTD.225(b).

The purpose of the new point (b) is to clarify that the competent authority monitors both the organisation and the FSTD during the EEP as part of its continuous oversight.

Point (c) of that AMC explains that an FSTD which is already in EEP may continue to be in EEP (indefinitely) unless the competent authority reverts its cycle to the recurrent period of 12 months.

Point (d) is developed as a result of the consultation on proposed hard law changes to clarify that the audit of the management system elements, described in point ARA.FSTD.120(c)(3), may be performed remotely by the competent authority, taking into account the performance of the organisation. It should be noted that the scope of the audit is the safety management system and the compliance monitoring system as referred to in point ARA.FSTD.120(c)(3).

The text was consulted with the FSTD focal points of the Member States on 10 June 2024. No changes were proposed following that consultation.

Subpart MED SPECIFIC REQUIREMENTS RELATING TO AERO-MEDICAL CERTIFICATION is amended as follows:

SUBPART MED - SPECIFIC REQUIREMENTS RELATING TO AERO-MEDICAL CERTIFICATION

SECTION I — GENERAL

AMC1 ARA.MED.120 Medical assessors

EXPERIENCE AND KNOWLEDGE

Medical assessors should:

(a) have considerable experience of aero-medical practice, having held AME privileges and having undertaken a minimum of 200 class 1 or class 3 medical examinations, or equivalent;

(b) undergo specific training on the regulatory processes and aero-medical certification of referred cases; and

(~~b~~c) maintain their medical professional competence in aviation medicine. The following should count towards maintaining medical professional competence:

(1) undertaking regular refresher training;

(2) participating in international aviation medicine conferences;

(3) undertaking research activities, including publication of results of the research.

Rationale	*RMT.0287*
The rulemaking group and the discussions in the Medical Experts' Group (MEG) highlighted the importance of having properly trained and qualified medical assessors making decisions in difficult cases, such as referred or secondary review cases, and performing oversight over the AMEs and AeMCs. Consequently, the rulemaking group proposed to clarify the previous wording and add a point asking for the medical assessors to be trained on regulatory processes and the aero-medical certification process of the respective Member States. In reaction to comments received during the EASA Committee meetings, EASA was asked to keep only the performance-based criteria of 200 examinations as an AME rather than a fixed period of time. Additionally, EASA was asked to enable the possibility to use an equivalent alternative for the Member States where the availability of highly experienced AMEs is limited.	

In this context, and following the comments mentioned above, this AMC is updated to provide clear information regarding the intention and meaning of the medical assessors' experience and knowledge provisions.

AMC2 ARA.MED.120 Medical assessors

TASKS

Medical assessors' tasks ~~should~~ include:

(a) ~~provide~~ approving and overseeing lectures in basic, advanced and refresher training courses for aero-medical examiners (AMEs) and aero-medical centres (AeMCs).~~;~~ Medical assessors may also deliver lectures during those training courses provided that a procedure is in place to avoid conflict of interest;

(b) carrying out supervision and audits of AeMCs, AMEs and AME training facilities; ~~and~~

(c) performing the aero-medical assessment of applicants for, or holders of, medical certificates ~~after~~ in the case of consultation, referral ~~to the licensing authority~~ or secondary review, or when medical certificates have been issued by non-compliant AMEs;~~.~~

(d) certifying and overseeing AeMCs and AMEs, including review of medical files submitted by them to the competent authority;

(e) managing medical files including transfers of medical files in the case of a change of state of licence issue;

(f) assisting AMEs and AeMCs, on their request, regarding aero-medical fitness assessments in borderline and difficult cases or cases not regulated in Part-MED or Part-ATCO.MED of Regulation (EU) 2015/340, as applicable; and

(g) issuing a medical certificate if a case is referred or if corrections to the information of a medical certificate are necessary.

Rationale *RMT.0287*

The rulemaking group and the discussions in the Medical Experts' Group (MEG) highlighted the importance of a clear definition of the main tasks of the medical assessors in order to fulfil the requirements set out in Annex IV and Annex VI to the Aircrew Regulation.

Consequently, the rulemaking group proposed the clarification of the previous wording and the addition of several new points to clarify the main tasks expected to be performed by the medical assessors.

In this context, this AMC is updated to provide clear information regarding the intention and meaning of the provisions on the medical assessors' tasks.

AMC3 ARA.MED.120 Medical assessors

DELEGATION OF MEDICAL ASSESSOR TASKS

The medical assessor may delegate certain tasks to other staff designated by the competent authority or other persons contracted by the competent authority. The competent authority should ensure that such person has relevant training and experience for the delegated task and that the entire process is properly documented.

Rationale	*RMT.0287*
The rulemaking group and the discussions in the Medical Experts' Group (MEG) highlighted the fact that many Member States face staffing difficulties regarding the medical assessors and, to mitigate this, it is important for the medical assessors to be able to delegate certain tasks that do not require specific aero-medical knowledge or are not linked with medical confidentiality. Consequently, the rulemaking group proposed to add a new AMC to enable the possibility to delegate certain tasks.	

GM1 ARA.MED.120 Medical assessors

DELEGATION OF MEDICAL ASSESSOR TASKS

Properly qualified medical assessors are essential for maintaining flight safety and an efficient and functional aero-medical system. Medical assessors, like any inspector of the competent authority, should, by their qualifications and competencies, command the professional respect of the personnel and organisations they inspect, authorise or oversee. These guidelines aim to establish possible solutions to optimise the use of qualified medical assessors as well as temporary solutions until properly qualified medical assessors are readily available. These guidelines should be interpreted and implemented only to the extent that they provide for sound and effective oversight in accordance with the principles of safety risk management.

For all of the medical assessor tasks, the support staff may provide administrative support with regard to the paperwork and preparation work. Furthermore, some tasks may be partially delegated to other staff members of the competent authority or other persons contracted by the competent authority. The medical assessor should select to whom the tasks are delegated based on their qualifications in order to ensure that the entire performance is in line with the applicable provision both in the field of aviation and in the medical field and is properly documented. The compliance monitoring system of the competent authority should ensure that delegation of certain tasks has no negative impact on flight safety and data protection.

In order to maintain their medical proficiency, medical assessors may act as an AME subject to a proper procedure being in place to avoid conflict of interest.

The following steps may be considered when required:

(a) Employment of a not fully qualified medical assessor

When recruiting a fully qualified medical assessor is not possible, the competent authority may employ a medical doctor to be trained and nominated as a medical assessor once the training is finalised. The performance of these doctors should be supervised by a qualified medical assessor from the pool of experts.

(b) Assignment of the role of a team member to qualified inspectors (e.g. assessing the SMS system of an AeMC)

In this context, the qualified inspectors performing duties within the inspection/oversight team are expected to document their work and to report to the medical assessor as the accountable person for the process.

(c) Use of appropriately qualified medical assessors or AMEs from a pool of experts

The use of AMEs or medical assessors from a pool of experts should be limited to the sharing of experts to cover unplanned activity or temporary/transitional shortage of expertise rather than a consistent long-term use.

The following types of pools of experts may be considered:

— qualified AMEs;

— medical assessors from the NCAs of other Member States or from EASA;

— medical assessors/AMEs from military aviation.

The following issues should be assessed and the associated risks mitigated in the case of using a pool of experts:

— assessment and oversight of the expert's performance as well as enforcement in case of non-compliance;

— authorisation of the expert to access medical practices, investigate, conduct interviews and collect evidence;

— financial, contracting and administrative aspects;

— recurrent training on administrative procedures;

— ability of the nominated expert to write reports and findings;

— avoidance of conflict of interest;

— sustainability (i.e. to avoid relying permanently on the pool of experts);

— commercial sensitivity of AMEs/AeMCs, cultural issues;

— data protection issues;

— language barriers;

— recognition between Member States, including the right to practice medicine in a different State and medical indemnity/liability insurance.

Bilateral sharing of experts is convenient when:

— the requesting authority is aware of the resources available in the resource provider;

— the agreement between the NCAs exists or is easy to establish;

— the planning for the availability of the resources can easily be managed.

Whether the sharing of medical assessors is concluded directly between two NCAs or through a sharing platform, sustainability can only be ensured if all stakeholders are willing to consider global optimisation as a priority. The challenge is that the management system of each NCA may systematically reduce its resources so that all qualified medical assessors are occupied at all times. Such planning strategy does not provide any extra margin for contingencies and may easily drift towards understaffing. It is always difficult to swiftly adjust the number of permanently employed experts to the short-term oversight needs. Therefore, while attempting to 'optimise' its own resources, each NCA may rely more and more on the experts from other

NCAs and further reduce its staff. While this may work for a limited period of time, in the long run the sharing of experts may simply become impossible as all NCAs will be requesting qualified medical assessors while no NCA would be able to provide any. A similar reasoning applies when experts from the industry are shared.

The concept of sharing implies availability of resources. Availability means extra capacity. Therefore all stakeholders involved in the sharing are expected to coordinate their staffing strategies globally. This ensures global optimisation by reallocating resources so that no expert is underused and that the costs are shared based on the level of support obtained. Additionally, it is expected that activity planning is coordinated among all involved stakeholders.

Rationale *RMT.0287*

Following the request of several Member States, EASA developed a position paper on the tasks of the medical assessors that was shared with the MEG, Aircrew TeB and the MAB.

Based on the above-mentioned position paper, the rulemaking group developed new GM to illustrate possible solutions to the low availability of fully qualified medical assessors allowing Member States to qualify medical assessors without lowering the safety standards.

The draft was extensively discussed by the Medical Experts' Group (MEG) highlighting the importance of having fully trained and experienced medical assessors in order to fulfil the requirements set of in Annex IV and Annex VI to the Aircrew Regulation in the interest of flight safety.

AMC1 ARA.MED.125 Referral to the licensing authority

~~**REFERRAL TO THE LICENSING AUTHORITY**~~

(a) The aero-medical section of the licensing authority should supply the AeMC or AME with all necessary information that led to the decision on aero-medical fitness.

(b) The aero-medical section of the licensing authority should ensure that ~~unusual or~~ borderline and difficult cases or those not regulated in Part-MED or Part-ATCO.MED, as applicable, are evaluated on a common basis.

(c) Each competent authority should define the time limit for the assessment of referred cases in their procedure regarding the management of referrals.

Rationale *RMT.0287*

A small number of Member States explained via the MEG meetings that in relation to the medical-related tasks it should be clarified that these should be performed by the aero-medical section within the competent/licensing authority. This is especially important for the Member States for which there are multiple competent/licensing authorities.

Consequently, the rulemaking group proposed to, in addition to the clarifications of the updated definitions of the terms 'licensing authority' and 'competent authority' adopted with the previous update to Part-MED, further clarify the previous wording and add in several key AMC the term 'aero-medical section' in front of the competent/licensing authority to clarify that these tasks are expected to be performed by the medical assessors or other staff of the aero-medical section.

This is not intended to impact the organisational structure of such authorities; 'aero-medical section' is a term aimed to illustrate the responsibility, not the structure itself as there are several models existing with aero-medical sections, aero-medical departments, aero-medical bureau or aero-medical team within the FCL section, etc.

During the MEG discussions as well as during the EASA standardisation activities it was noticed that in many cases several procedures do not have a timeline defined. As explained multiple times during the standardisation inspections, it is expected that procedures include who performs a specific task, how and when. This is especially important for procedures that directly impact individuals or the applicants. For this reason, a new point was added to recommend the introduction of a time limit for the assessment of referrals.

AMC1 ARA.MED.128 Consultation procedure

This procedure should include at least a summary of the consultation process and related documentation.

Rationale *RMT.0287*

The rulemaking group and the discussions in the Medical Experts' Group (MEG) highlighted the need to have the consultation documented to ensure traceability of the decision and allow proper oversight.

Consequently, the rulemaking group proposed to add a new AMC to clarify what should be the minimum content when documenting the consultation procedure.

AMC1 ARA.MED.130 Medical certificate format

STANDARD EASA MEDICAL CERTIFICATE FORMAT

The format of the medical certificate should be as shown below.

Competent authority name and logo (English and any language(s) determined by the competent authority) EUROPEAN UNION (English only) ~~Class 1/2/LAPL~~ MEDICAL CERTIFICATE pertaining to a Part-FCL licence (English and any language(s) determined by the competent authority) Issued in accordance with Part-MED This medical certificate complies with ICAO standards, except for the LAPL medical certificate		Requirements ~~"~~'European Union'~~"~~ to be deleted for non-EU Member States Size of each page shall be one eighth A4

(English and any language(s) determined by the competent authority)		

I	National language(s)/*Authority that issued or is to issue the pilot licence*:
III	National language(s)~~:~~/*Certificate number*
IV	National language(s)~~:~~/ *Last and first name of holder:*
XIV	National language(s)~~:~~/*Date of birth: (dd/mm/yyyy):*
VI	National language(s)/*Nationality(ies):*
VII	National language(s)/ *Signature of holder:*

2

XIII	National language(s)/*Limitations:* Code:~~-~~ ~~Description~~ Operational remark:
X	National language(s)/**Date of issue:* *(dd/mm/yyyy)* Name and ~~S~~signature of the issuing AME/medical assessor /~~(~~GMP~~)~~:
XI	National language(s)/*Seal or Stamp:*

	IX Nat. lang(s)/ Expiry date of this certificate	Class 1 ~~single pilot commercial operations carrying passengers~~ (dd/mm/yyyy or 'N/A')			
		Class 1 single-pilot commercial operations carrying passengers (dd/mm/yyyy or 'N/A')			
		Class 2 (dd/mm/yyyy or 'N/A')			
		LAPL (dd/mm/yyyy)			
	Nat. lang(s)~~.~~/*Examination date*: (dd/mm/yyyy)				
	Type of examination	Last	Next		
			Class 1	Class 2	LAPL
	ECG				
	Audiogram (For class 1, and for class 2 with IR or en route IR)				
	Ophthalmological examination				
	Other information				

MED.A.020 Decrease in medical fitness

(a) Licence holders shall not exercise the privileges of their licence and related ratings or certificates, and student pilots shall not fly solo, at any time when they:

(1) are aware of any decrease in their medical fitness that might render them unable to safely exercise those privileges;

(2) take or use any prescribed or non-prescribed medication that is likely to interfere with the safe exercise of the privileges of the applicable licence; ~~or~~

(3) receive any medical, surgical or other treatment that is likely to interfere with the safe exercise of the privileges of the applicable licence. ~~flight safety.~~

(b) In addition, licence holders shall, without undue delay and before exercising the privileges of their licence, seek aero-medical advice from the AeMC, AME or GMP, as applicable, when they:

(1) have undergone a surgical operation or invasive procedure;

(2) have commenced the regular use of any medication;

(3) have suffered any significant personal injury involving incapacity to function as a member of the flight crew;

(4) have been suffering from any significant illness involving incapacity to function as a member of the flight crew;

(5) are pregnant;

(6) have been admitted to hospital or medical clinic; ~~or~~

(7) first require correcting lenses.

* Date of issue is the date the certificate is issued and signed

Rationale	*RMT.0287*
The rulemaking group and the discussions in the Medical Experts' Group (MEG) highlighted the need to make certain updates to the medical certificate template. Consequently, the rulemaking group proposed to adjust the medical certificate template as detailed above to mirror the updates of the implementing rules.	

AMC1 ARA.MED.135(a) Aero-medical forms

APPLICATION FORM FOR A MEDICAL CERTIFICATE

The form referred to in point ARA.MED.135(a) should reflect the information indicated in the following form and corresponding instructions for completion.

LOGO

CIVIL AVIATION ADMINISTRATION/MEMBER STATE

APPLICATION FORM FOR A MEDICAL CERTIFICATE

MEDICAL IN CONFIDENCE

Complete this page fully and in block capitals - Refer to instructions for completion.

(1) State of licence issue:	(2) Medical certificate applied for: class 1 ☐ class 2 ☐ LAPL ☐ class 3 ☐		
(3) Surname:	(4) Previous surname(s):		(12) Application: Initial ☐ Revalidation/Renewal ☐
(5) Forename(s):	(6) Date of birth(dd/mm/yyyy):	(7) Sex: Male ☐ Female ☐	(13) ~~Reference~~ Medical certificate/EAMR ID number:
(8) Place and country of birth:	(9) Nationality:		(14) Type of licence applied for:
(10) Permanent address: Country: Telephone No.: Mobile No.: E-mail:	(11) Postal address (if different): Country: Telephone No.:		(15) Occupation (principal): (16) Employer: (17) Last medical examination: Date: Place: Completed: No ☐ Yes ☐

(18) Licence(s) held (type): Licence number: State of issue:	(19) Any limitations on licence(s)/medical certificate held No ☐ Yes ☐ Details:
(20) Have you ever had a medical certificate denied, suspended or revoked by any licensing authority? No ☐ Yes ☐ Date: Country: Details:	(21) Flight time total: / (22) Flight time since last medical: (23) Aircraft class/type(s) presently flown:
(24) Any aviation accident or ~~reported incident~~ medical event whilst exercising the privileges of the licence since the last medical examination? No ☐ Yes ☐ Date: Place: Details:	(25) ~~Type of flying intended~~ Current/intended pilot activity: Commercial ☐ Non-commercial ☐ Other ..... Single-pilot ☐ Multi-pilot ☐ (26) ~~Present flying activity~~ Current/intended ATC activity: ADI ☐ APS ☐ ACS ☐ ADV ☐ APP ☐ ACP ☐
(27) Do you drink alcohol? ☐ No ☐ Yes, state average weekly amount: Do you use drugs? ☐ No ☐ Yes, state the type: (29) Do you smoke tobacco? ☐ No, never ☐ No, date stopped: ☐ Yes, state type and amount:	(28) Do you currently use any medication? No ☐ Yes ☐ State medication, dose, date started and why:

General and medical history: Do you have, or have you ever had, any of the following? (Please tick a response for each question**). If yes, give details in the remarks section (30).**

	Yes	No		Yes	No		Yes	No	**Family history of:**	Yes	No
101 Eye trouble/eye operation			112 Nose, throat or speech disorder			123 Malaria or other tropical disease			170 Heart or vascular disease		
102 Spectacles and/or contact lenses ever worn			113 Head injury or concussion			124 A positive HIV test			171 High blood pressure		
			114 Frequent or severe headaches			125 Sexually transmitted disease			172 High cholesterol level		
103 Spectacle/contact lens prescriptions change since last medical exam.			115 Dizziness or fainting spells			126 Sleep disorder/apnoea syndrome			173 Epilepsy		
			116 Unconsciousness for any reason			127 Musculoskeletal illness/impairment			174 Mental illness or suicide		
104 Hay fever, other allergy			117 Neurological disorders; stroke, epilepsy, seizure, paralysis, etc.			128 Any other illness or injury			175 Diabetes		
105 Asthma, lung disease						129 Admission to hospital			176 Tuberculosis		
106 Heart or vascular trouble			118 Psychological/psychiatric trouble of any sort			130 Visit to medical practitioner or mental health specialist since last medical examination			177 Allergy/asthma/eczema		
107 High or low blood pressure									178 Inherited disorders		
108 Kidney stone or blood in urine			119 ~~Alcohol/drug/substance abuse~~ misuse of psychoactive substances			131 Refusal of life insurance			179 Glaucoma		
109 Diabetes, hormone disorder			120 Attempted suicide or self-harm			132 Refusal of ~~flying~~ aviation licence					
110 Stomach, liver or intestinal trouble			121 Motion sickness requiring medication			133 Medical rejection from or for military service			**Females only:**		
									150 Gynaecological, menstrual problems		
111 Deafness, ear disorder			122 Anaemia/sickle cell trait/other blood disorders			134 Award of pension or compensation for injury or illness			151 Are you pregnant?		

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

(31) **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 licensing 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 ~~authorise the release of~~ declare that I have been informed and I understand that all information provided to my AME contained in this report and ~~any or all~~ its attachments ~~to the AME and, where necessary,~~ and all information which is provided to my licensing authority and that relates to me, may be released to the medical assessor of ~~the~~ my licensing authority, other health professionals and medical administration staff as part of the aero-medical assessment process and to the medical assessor of the competent authority of my AME, recognising that these documents or electronically stored data are to be used for the completion of an aero-medical assessment and for oversight purposes ~~will become and remain the property of the licensing authority~~, providing that I or my physician may have access to them ~~according to~~ in accordance with national law. Medical confidentiality will be respected at all times.

NOTIFICATION OF DISCLOSURE OF PERSONAL DATA: I hereby declare that I have been informed and I understand that the data contained in my medical certificate ~~according to~~ in accordance with point ARA.MED.130, or point ATCO.AR.F.005 of Regulation (EU) 2015/340 if applicable, may be electronically stored and made available to my AME in order to provide historical data required in point MED.A.035(b)(2)(ii)/(iii) or, if applicable, points ATCO.MED.A.035(b)(2)(ii) or ATCO.MED.A.035(b)(2)(iii), and to the medical assessors of the competent authorities of the Member States in order to facilitate the enforcement of point ARA.MED.150(c)(4).

Date	Signature of applicant	Signature of AME/(GMP)/(medical assessor)

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FORM FOR A MEDICAL CERTIFICATE

This application form and all attached report forms will be transmitted to the licensing authority. Medical confidentiality shall be respected at all times.

The applicant should personally complete, in full, all questions (sections) on the application form. Writing should be legible and in block capitals, using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any questions, a plain sheet of paper should be used, bearing the applicant's name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the application form for a medical certificate.

Failure to complete the application form in full, or to write legibly, may result in non-acceptance of the application form. The making of false or misleading statements or the withholding of relevant information in respect of this application may result in criminal prosecution, denial of this application and/or withdrawal of any medical certificate(s) granted.

1. LICENSING AUTHORITY: State name of country ~~this application is to be forwarded to~~ that has issued the pilot or ATCO licence or where a licence has not been issued, the country where the applicant intends to apply for a licence.	**17. LAST APPLICATION FOR A MEDICAL CERTIFICATE:** State date (day, month, year) and place (town, country). Initial applicants state 'NONE'.
2. MEDICAL CERTIFICATE APPLIED FOR: Tick appropriate box representing the type of medical certificate applied for, e.g. class 1, class 2, class 3 or LAPL. ~~Class 1: Professional Pilot~~ ~~Class 2: Private Pilot~~ ~~LAPL~~	**18. LICENCE(S) HELD (TYPE):** State type of licence(s) held. Enter licence number and State of issue. If no licences are held, state 'NONE'.
3. SURNAME: State surname/family name.	**19. ANY LIMITATIONS ON THE LICENCE(S)/MEDICAL CERTIFICATE:** Tick appropriate box and give details of any limitations on your licence(s)/medical certificate, e.g. vision, colour vision, safety pilot, etc.
4. PREVIOUS SURNAME(S): If your surname or family name has changed for any reason, state previous name(s).	**20. MEDICAL CERTIFICATE DENIAL, SUSPENSION OR REVOCATION:** Tick 'YES' box if you have ever had a medical certificate denied, suspended or revoked~~, even if only temporary~~. If 'YES', state date (dd/mm/yyyy) and country where it occurred.
5. FORENAME(S): State first and middle names (maximum three).	**21. FLIGHT TIME TOTAL:** State total number of hours flown.
6. DATE OF BIRTH: Specify in order dd/mm/yyyy.	**22. FLIGHT TIME SINCE LAST MEDICAL:** State number of hours flown since your last medical examination.
7. SEX: Tick appropriate box.	**23. AIRCRAFT CLASS/TYPE(S) PRESENTLY FLOWN:** State name of principal aircraft flown, e.g. Boeing 737, Cessna 150, etc.
8. PLACE AND COUNTRY OF BIRTH: State town and country of birth.	**24. ANY AVIATION ACCIDENT OR ~~REPORTED INCIDENT~~ MEDICAL EVENT WHILST EXERCISING THE PRIVILEGES OF THE LICENCE SINCE THE LAST MEDICAL EXAMINATION:** If 'YES' box ticked, state date (dd/mm/yyyy) and country of ~~accident/incident~~ occurrence and provide details.
9. NATIONALITY: State name of country of citizenship.	**25. ~~TYPE OF FLYING INTENDED~~ CURRENT/INTENDED PILOT ACTIVITY:** ~~State whether airline, charter, single-pilot, commercial air transport, carrying passengers, agriculture, pleasure, etc.~~ Please tick the appropriate box regarding the current/intended activity during the following certification period: • Commercial, non-commercial or other (for other, please specify the type of operation) • Single-pilot or multi-pilot
10. PERMANENT ADDRESS: State permanent postal address and country. Enter telephone area code as well as telephone number.	**26. ~~PRESENT FLYING ACTIVITY~~ CURRENT/INTENDED ATC ACTIVITY:** ~~Tick appropriate box to indicate whether you fly as the SOLE pilot or not.~~ Please tick the appropriate box regarding the current/intended activity during the following certification period e.g. ADI, APS, ACS
11. POSTAL ADDRESS (IF DIFFERENT): If different from permanent address, state full current postal address including telephone number and area code. If the same, enter 'SAME'.	**27. DO YOU DRINK ALCOHOL OR USE DRUGS?** Tick applicable box. If yes, state weekly alcohol consumption e.g. 2 litres of beer.
12. APPLICATION: Tick appropriate box.	**28. DO YOU CURRENTLY USE ANY MEDICATION?:** If 'YES', give full details - name, how much you take and when, etc. Include any non-prescription medication.

13. ~~REFERENCE~~ MEDICAL CERTIFICATE/EAMR ID NUMBER: State ~~reference~~ medical certificate number allocated to you by the licensing authority/EAMR ID unique number Initial applicants enter 'NONE'.	**29. DO YOU SMOKE TOBACCO?** Tick applicable box. Current smokers state type (cigarettes, cigars, pipe) and amount (e.g. 2 cigars daily; pipe – 1 oz. weekly)
14. TYPE OF LICENCE APPLIED FOR: State type of licence applied for from the following list: ~~Aeroplane~~ Airline Transport Pilot Licence* Multi-Pilot Licence* Commercial Pilot Licence/Instrument Rating* Commercial Pilot Licence* Private Pilot Licence/Instrument Rating* Private Pilot Licence* Sailplane Pilot Licence Balloon Pilot Licence Light Aircraft Pilot Licence* ~~And whether Fixed Wing / Rotary Wing / Both~~ Air Traffic Controller Licence Other – Please specify *Please specify whether Fixed Wing / Rotary Wing / Both	**30. GENERAL AND MEDICAL HISTORY** All items under this heading, from number 101 to 179 inclusive, should have the answer 'YES' or 'NO' ticked. You should tick 'YES' if you have ever had the condition in your life and describe the condition and approximate date in the ~~(30)~~ remarks section (30). All questions asked are medically important even though this may not be readily apparent. Items numbered 170 to 179 relate to immediate family history, whereas items numbered 150 to 151 should be answered by female applicants only. ~~If information has been reported on a previous application form for a medical certificate and there has been no change in your condition, you may state 'Previously reported; no change since'. However, you should still tick 'YES' to the condition.~~ Do not report occasional common illnesses such as colds.
15. OCCUPATION (PRINCIPAL): Indicate your principal employment.	
16. EMPLOYER: If principal occupation is pilot, then state employer's name or if self-employed, state 'self'.	**31. DECLARATION AND ~~CONSENT TO OBTAINING AND RELEASING INFORMATION~~ NOTIFICATION OF DISCLOSURE OF PERSONAL DATA:** Do not sign or date these declarations until indicated to do so by the AME/GMP who will act as witness and sign accordingly.

Rationale *RMT.0287*

The rulemaking group identified the need to make certain updates to the aero-medical form templates to match the updates to the implementing rules. Furthermore, the need was identified to update the instructions for filling in the forms to keep them fit for purpose.

Consequently, the rulemaking group proposed the updates to the application form and the applicable instructions above.

AMC1 ARA.MED.135(b);(c) Aero-medical forms

MEDICAL EXAMINATION REPORT FORMS

The forms referred to in points ARA.MED.135(b) and (c) should reflect the information indicated in the following forms and corresponding instructions for completion.

MEDICAL EXAMINATION REPORT FORM FOR CLASS 1, ~~& CLASS~~ 2 & 3 APPLICANTS

(201) Examination category	(202) Height (cm)	(203) Weight (kg)	(204) Colour eye	(205) Colour hair	(206) Blood pressure-seated (mmHg)		(207) Pulse - resting	
Initial ☐							Rate (bpm)	Rhythm: regular ☐
Revalidation ☐ Renewal ☐								irregular ☐
Special referral ☐					Systolic	Diastolic		

Clinical exam: Check each item

	Normal	Abnormal		Normal	Abnormal
(208) Head, face, neck, scalp			(218) Abdomen, hernia, liver, spleen		
(209) Mouth, throat, teeth			(219) Anus, rectum		
(210) Nose, sinuses			(220) Genito-urinary system		
(211) Ears, drums, eardrum motility			(221) Endocrine system		
(212) Eyes - orbit & adnexa; visual fields			(222) Upper & lower limbs, joints		
(213) Eyes - pupils and optic fundi			(223) Spine, other musculoskeletal		
(214) Eyes - ocular motility; nystagmus			(224) Neurologic - reflexes, etc.		
(215) Lungs, chest, breasts			(225) ~~Psychiatric~~ Mental health		
(216) Heart			(226) Skin, identifying marks and lymphatics		
(217) Vascular system			(227) General systemic		

(228) **Notes:** Describe every abnormal finding. Enter applicable item number before each comment.

Visual acuity

(229) *Distant vision at 5m/6m*

	Uncorrected		Spectacles	Contact lenses
Right eye		Corr. to		
Left eye		Corr. to		
Both eyes		Corr. to		

(230) *Intermediate vision* N14 at 100 cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(231) *Near vision* N5 at 30-50 cm

	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(232) **Spectacles**

Yes ☐ No ☐

Type:

(233) **Contact lenses**

Yes ☐ No ☐

Type:

Refraction	Sph	Cyl	Axis	Add
Right eye				
Left eye				

(313) **Colour perception** Normal ☐ Abnormal ☐

Pseudo-isochromatic plates No of plates:	Type: Ishihara (24 plates) No of errors:

(234) **Hearing** (when 239/241 not performed)

	Right ear	Left ear
Conversational voice test (2m) with back turned to examiner	Yes ☐ No ☐	Yes ☐ No ☐

Audiometry

Hz	500	1000	2000	3000
Right				
Left				

(236) **Pulmonary function**

FEV_1/FVC _____ %

Normal ☐ Abnormal ☐

(237) **Haemoglobin**

_____ _____ (***unit)***

Normal ☐ Abnormal ☐

(236a) **OSA screening**

Applicant at risk of OSA: Yes ☐ No ☐

Specify if applicant undergoes treatment for OSA:

(235) **Urinalysis** Normal ☐ Abnormal ☐

Glucose	Protein	Blood	Other

Accompanying reports

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) **AME recommendation:**

Name of applicant: Date of birth: Reference number:

☐ Fit for class: ----------

☐ Medical certificate issued by undersigned (copy attached) for class: ----------

☐ Unfit for class: ----------

☐ Deferred for further evaluation. If yes, why and to whom?

(248) **Comments, limitations**

(249) **AME declaration:**

I hereby certify that I/my AME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

(250) Place and date:	AME name and address:	AME certificate No.:
AME signature:	E-mail: Telephone No.:	

	Telefax No.:	

Shaded areas do not require completion

MEDICAL EXAMINATION REPORT FORM FOR LAPL APPLICANTS

(201) Examination category	(202) Height (cm)	(203) Weight (kg)	(204) Colour eyes	(205) Colour hair	(206) Blood pressure-seated (mmHg)		(207) Pulse - resting	
Initial ☐							Rate (bpm)	Rhythm: regular ☐ irregular ☐
Revalidation ☐ Renewal ☐					Systolic	Diastolic		
Special referral ☐								

Clinical exam: Check each item	Normal	Abnormal		Normal	Abnormal
(208) Head, face, neck, scalp			(218) Abdomen, hernia, liver, spleen		
(209) Mouth, throat, teeth			(219) Anus, rectum		
(210) Nose, sinuses			(220) Genito-urinary system		
(211) Ears, drums, eardrum motility			(221) Endocrine system		
(212) Eyes - orbit & adnexa; visual fields			(222) Upper & lower limbs, joints		
(213) Eyes - pupils and optic fundi			(223) Spine, other musculoskeletal		
(214) Eyes - ocular motility; nystagmus			(224) Neurologic - reflexes, etc.		
(215) Lungs, chest, breasts			(225) ~~Psychiatric~~ Mental health		
(216) Heart			(226) Skin, identifying marks and lymphatics		
(217) Vascular system			(227) General systemic		

(228) **Notes:** Describe every abnormal finding. Enter applicable item number before each comment.

Visual acuity

(229) *Distant vision at 5m /6m*

	Uncorrected		Spectacles	Contact lenses
Right eye		Corr. to		
Left eye		Corr. to		
Both eyes		Corr. to		

(230) *Intermediate vision* N14 at 100 cm	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(231) *Near vision* N5 at 30-50 cm	Uncorrected		Corrected	
	Yes	No	Yes	No
Right eye				
Left eye				
Both eyes				

(232) **Spectacles**

Yes ☐ No ☐

Type:

(233) **Contact lenses**

Yes ☐ No ☐

Type:

Refraction	Sph	Cyl	Axis	Add
Right eye				
Left eye				

(313) **Colour perception** Normal ☐ Abnormal ☐

Pseudo-isochromatic plates No of plates:

Type: Ishihara (24 plates) No of errors:

(234) **Hearing** (when 239/241 not performed)

	Right ear	Left ear
Conversational voice test (2m) with back turned to examiner	Yes ☐ No ☐	Yes ☐ No ☐

Audiometry				
Hz	500	1000	2000	3000
Right				
Left				

(236) **Pulmonary function**

FEV_1/FVC _____ %

Normal ☐ Abnormal ☐

(237) **Haemoglobin**

_____ _____ (***unit***)

Normal ☐ Abnormal ☐

(235) **Urinalysis** Normal ☐ Abnormal ☐

Glucose	Protein	Blood	Other

Accompanying reports

	Not performed	Normal	Abnormal/Comment
(238) ECG			
(239) Audiogram			
(240) Ophthalmology			
(241) ORL (ENT)			
(242) Blood lipids			
(243) Pulmonary function			
(244) Other (what?)			

(247) **AME/GMP recommendation:**

Name of applicant: Date of birth: Reference number:

☐ Fit for medical certificate for LAPL

☐ Medical certificate issued by undersigned (copy attached) for LAPL

☐ Unfit for class: ----------

☐ Deferred for further evaluation. If yes, why and to whom?

(248) **Comments, limitations**

(249) **AME/GMP 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.

(250) Place and date:	AME/GMP name and address:	AME certificate No./GMP identification No.:
AME/GMP signature:		

	E-mail: Telephone No.: Telefax No.:	

INSTRUCTIONS FOR COMPLETION OF THE MEDICAL EXAMINATION REPORT FORMS

The AME performing the examination should verify the identity of the applicant.

All questions (sections) on the medical examination report form should be completed in full. If an otorhinolaryngology examination report form is attached, then questions 209, 210, 211, and 234 may be omitted. If an ophthalmology examination report form is attached, then questions 212, 213, 214, 229, 230, 231, 232, and 233 may be omitted.

Writing should be legible and in block capitals using a ball-point pen. Completion of this form by typing/printing is also acceptable. If more space is required to answer any question, a plain sheet of paper should be used, bearing the applicant's name, the AME's name and signature, and the date of signing. The following numbered instructions apply to the numbered headings on the medical examination report form.

Failure to complete the medical examination report form in full, as required, or to write legibly, may result in non-acceptance of the application in total and may lead to withdrawal of any medical certificate issued. The making of false or misleading statements or the withholding of relevant information by an AME may result in criminal prosecution, denial of an application or withdrawal of any medical certificate(s) granted.

Shaded areas do not require completion for the medical examination report form for the LAPL.

201 EXAMINATION CATEGORY – Tick appropriate box.

Initial – Initial examination for either LAPL, class 1, ~~or~~ 2 or 3; also initial examination for upgrading from LAPL to class 2, or from class 2 to 1 (~~notate~~ insert 'upgrading' in box 248).

Renewal/Revalidation – Subsequent ROUTINE examinations.

Extended Renewal/Revalidation – Subsequent ROUTINE examinations, which include comprehensive ophthalmological and otorhinolaryngology examinations.

202 HEIGHT – Measure height, without shoes, in centimetres to nearest cm.

203 WEIGHT – Measure weight, in indoor clothes, in kilograms to nearest kg.

204 COLOUR EYE – State colour of applicant's eyes from the following list: brown, blue, green, hazel, grey, multi.

205 COLOUR HAIR – State colour of applicant's hair from the following list: brown, black, red, fair, bald.

206 BLOOD PRESSURE – Blood pressure readings should be recorded as Phase 1 for Systolic pressure and Phase 5 for Diastolic pressure. The applicant should be seated and rested. Recordings in mm Hg.

207 PULSE (RESTING) – The pulse rate should be recorded in beats per minute and the rhythm should be recorded as regular or irregular. Further comments if necessary may be written in section 228, 248 or separately.

208 to 227 inclusive constitute the general clinical examination, and each of the boxes should be marked (with a tick) as normal or abnormal.

208 HEAD, FACE, NECK, SCALP – To include appearance, range of neck and facial movements, symmetry, etc.

209 MOUTH, THROAT, TEETH – To include appearance of buccal cavity, palate motility, tonsillar area, pharynx and also gums, teeth and tongue.

210 NOSE, SINUSES – To include appearance and any evidence of nasal obstruction or sinus tenderness on palpation.

211 EARS, DRUMS, EARDRUM MOTILITY – To include otoscopy of external ear, canal, tympanic membrane. Eardrum motility by V~~v~~alsalva manoeuvre or by pneumatic otoscopy.

212 EYES – ORBIT AND ADNEXA; VISUAL FIELDS – To include appearance, position and movement of eyes and their surrounding structures in general, including eyelids and conjunctiva. Visual fields check by campimetry, perimetry or confrontation.

213 EYES – PUPILS AND OPTIC FUNDI – To include appearance, size, reflexes, red reflex and fundoscopy. Special note of corneal scars.

214 EYES – OCULAR MOTILITY, NYSTAGMUS – To include range of movement of eyes in all directions; symmetry of movement of both eyes; ocular muscle balance; convergence; accommodation; signs of nystagmus.

215 LUNGS, CHEST, BREASTS – To include inspection of chest for deformities, operation scars, abnormality of respiratory movement, auscultation of breath sounds. Physical examination of female applicant's breasts should only be performed with informed consent.

216 HEART – To include apical heartbeat, position, auscultation for murmurs, carotid bruits, palpation for trills.

217 VASCULAR SYSTEM – To include examination for varicose veins, character and feel of pulse, peripheral pulses, evidence of peripheral circulatory disease.

218 ABDOMEN, HERNIA, LIVER, SPLEEN – To include inspection of abdomen; palpation of internal organs; check for inguinal ~~inquinal~~ hernias in particular.

219 ANUS, RECTUM – Examination only on clinical indication ~~with~~ following an informed consent.

220 GENITO-URINARY SYSTEM – To include renal palpation; inspection palpation male/female reproductive organs only on clinical indication ~~with~~ following an informed consent.

221 ENDOCRINE SYSTEM – To include inspection, palpation for evidence of hormonal abnormalities/imbalance; thyroid gland.

222 UPPER AND LOWER LIMBS, JOINTS – To include full range of movements of joints and limbs, any deformities, weakness or loss. Evidence of arthritis.

223 SPINE, OTHER MUSCULOSKELETAL – To include range of movements, abnormalities of joints.

224 NEUROLOGIC – REFLEXES ETC. To include reflexes, sensation, power, vestibular system – balance, ~~r~~Romberg test, etc.

225 ~~PSYCHIATRIC~~ MENTAL HEALTH~~–~~ To include appearance, appropriate mood/thought, unusual behaviour.

226 SKIN, IDENTIFYING MARKS AND LYMPHATICS – To include inspection of skin; inspection, palpation for lymphadenopathy, etc. Briefly describe scars, tattoos, birthmarks, etc. which could be used for identification purposes.

227 GENERAL SYSTEMIC – All other areas, systems and nutritional status.

228 NOTES – Any notes, comments or abnormalities to be described – extra notes if required on separate sheet of paper, signed and dated.

229 DISTANT VISION AT 5/6 METRES – Each eye to be examined separately and then both together. First without correction, then with spectacles (if used) and lastly with contact lenses, if used. Record visual acuity in appropriate boxes. Visual acuity to be tested at either 5 or 6 metres with the appropriate chart for the distance.

230 INTERMEDIATE VISION AT 100 CM – Each eye to be examined separately and then both together. First without correction, then with spectacles if used and lastly with contact lenses if used. Record visual acuity in appropriate boxes as ability to read N14 at 100 cm (Yes/No).

231 NEAR VISION AT 30-50 CM. – Each eye to be examined separately and then both together. First without correction, then with spectacles if used and lastly with contact lenses, if used. Record visual acuity in appropriate boxes as ability to read N5 at 30-50 cm (Yes/No).

Note: Bifocal contact lenses and contact lenses correcting for near vision only are not acceptable.

232 SPECTACLES – Tick appropriate box signifying ~~if~~ whether spectacles are or are not worn by applicant. If used, state whether unifocal, bifocal, varifocal or look-over.

233 CONTACT LENSES – Tick appropriate box signifying if contact lenses are or are not worn. If worn, state type from the following list; hard, soft, gas-permeable or disposable.

313 COLOUR PERCEPTION – Tick appropriate box signifying if colour perception is normal or not. If abnormal; state number of plates of the first 15 of the pseudo-isochromatic plates (Ishihara 24 plates) have not been read correctly.

234 HEARING – Tick appropriate box to indicate hearing level ability as tested separately in each ear at 2 m.

235 URINALYSIS – State whether result of urinalysis is normal or not by ticking appropriate box. If no abnormal constituents, state NIL in each appropriate box.

236 PULMONARY FUNCTION – When required or on indication, state actual FEV_1/FVC value obtained in % and state ~~if~~ whether normal or not with reference to height, age, sex and race.

236(a) OSA screening: Determine the risk of OSA using appropriate diagnostic tool.

237 HAEMOGLOBIN – Enter actual haemoglobin test result and state units used. Then state whether normal value or not, by ticking appropriate box.

238 to 244 inclusive: ACCOMPANYING REPORTS – One box opposite each of these sections must be ticked. If the test is not required and has not been performed, then tick the NOT PERFORMED box. If the test has been performed (whether required or on indication) complete the normal or abnormal box as appropriate. In the case of question 244, the number of other accompanying reports must be stated.

247 AME RECOMMENDATION – The applicant's name, date of birth and reference number~~,~~ should be entered here in block capitals. The applicable class of medical certificate should be indicated by a tick in the appropriate box. If a fit assessment is recommended and a medical certificate has been issued, this should be indicated in the appropriate box. An applicant may be recommended as fit for a lower class of medical certificate (e.g. class 2), but also be deferred or recommended as unfit for a higher class of medical certificate (e.g. class 1). If an unfit recommendation is made, applicable Part-MED ~~paragraph~~ point references should be entered. If an applicant is deferred for further evaluation, the reason and the doctor or licensing authority to whom the applicant is referred should be indicated.

248 COMMENTS, LIMITATIONS, ETC. – The AME's findings and assessment of any abnormality in the history or examination, should be entered here. The AME should also state any limitation required.

249 AME DETAILS – The AME should sign the declaration, complete ~~his/her~~ his or her name and address in block capitals, contact details and lastly stamp the relevant section with ~~his/her~~ his or her designated AME stamp incorporating ~~his/her~~ his or her AME number. The GMP identification no. is the number provided by the national medical system.

250 PLACE AND DATE – The place (town or city) and the date of examination should be entered here. The date of examination is the date of the general examination and not the date of finalisation of the form. If the medical examination report is finalised on a different date, the date of finalisation should be entered in section 248 as 'Report finalised on .....'.

Rationale *RMT.0287*

The rulemaking group identified the need to make certain updates to the aero-medical forms templates to match the updates to the implementing rules. Furthermore, the need was identified to update the instructions for filling in the forms to keep them fit for purpose.

Consequently, the rulemaking group proposed the updates to the medical examination forms and the applicable instructions in the AMC above.

GM1 ARA.MED.135(b);(c) Aero-medical forms

OPHTHALMOLOGY AND OTORHINOLARYNGOLOGY EXAMINATION REPORT FORMS

The ophthalmology and otorhinolaryngology examination report forms may be used as indicated in the following forms and corresponding instructions for completion.

OPHTHALMOLOGY EXAMINATION REPORT FORM

Complete this page fully and in block capitals – Refer to instructions for completion.

MEDICAL IN CONFIDENCE

Applicant's details

(1) State applied to:	(2) Medical certificate applied for: class 1 ☐ class 2 ☐ class 3 ☐		(12) Application: Initial ☐ Revalidation/Renewal ☐
(3) Surname:	(4) Previous surname(s):		
(5) Forename(s):	(6) Date of birth:	(7) Sex: Male ☐ Female ☐	(13) Reference number:

(301) ~~**Consent to release of medical information:**~~ I hereby ~~authorise the release of~~ declare that I have been informed and I understand that all information provided to my AME, contained in this report and ~~any or all~~ its attachments ~~to the AME and, where necessary~~, may be released to the medical assessor of ~~the~~ my licensing authority and to the medical assessor of the competent authority of my AME, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and for oversight purposes ~~will become and remain the property of the licensing authority~~, providing that I or my physician may have access to them ~~according to~~ in accordance with national law. Medical confidentiality will be respected at all times.

---------- Date ---------- Signature of applicant ~~Signature of AME~~

(302) Examination category:
- Initial ☐
- Revalidation ☐
- Renewal ☐
- Special referral ☐

(303) Ophthalmological history:

Clinical examination

Check each item		Normal	Abnormal
(304) Eyes, external & eyelids			
(305) Eyes, Exterior (slit lamp, ophth.)			
(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 prisme dioptres)

Distant at 5m/6m	Near at 30-50 cm
Ortho	Ortho
Eso	Eso
Exo	Exo
Hyper	Hyper
Cyclo	Cyclo
Tropia Yes No	Phoria Yes No
Fusional reserve testing Not performed	Normal Abnormal

(313) *Colour perception*

Pseudo-Isochromatic plates	Type: Ishihara (24 plates)
No of plates:	No of errors:
Advanced colour perception testing indicated Yes No Method:	
Class 1&2	Colour SAFE Colour UNSAFE
For ATCOs	Normal trichromat Yes ☐ No ☐

Visual acuity

(314) *Distant vision at 5m/6m*

	Uncorrected		Spectacles	Contact lenses
Right eye		Corrected to		
Left eye		Corrected to		
Both eyes		Corrected to		

(315) *Intermediate vision at 1m*

	Uncorrected		Spectacles	Contact lenses
Right eye		Corrected to		
Left eye		Corrected to		
Both eyes		Corrected to		

(316) *Near vision at 30-50cm*

	Uncorrected		Spectacles	Contact lenses
Right eye		Corrected to		
Left eye		Corrected to		
Both eyes		Corrected to		

(317) *Refraction*	Sph	Cylinder	Axis	Near (add)
Right eye				
Left eye				
Actual refraction examined Spectacles prescription based				

(318) *Spectacles*

Yes ☐ No ☐
Type:

(319) *Contact lenses*

Yes ☐ No ☐
Type:

(320) *Intra-ocular pressure*

Right (mmHg)	Left (mmHg)
Method	Normal ☐ Abnormal ☐

(321) **Ophthalmological remarks ~~and recommendation~~:**

(322) **Examiner's declaration:**

I hereby certify that I~~/my AME group~~ have personally examined or assessed the eye specialist's examination report of the applicant named ~~o~~in this medical examination report and that this report with any attachment embodies ~~my~~ the findings completely and correctly.		
(323) Place and date: AME or eye specialist signature:	~~Ophth examiner's n~~Name and address: (block capitals) E-mail: Telephone No.: Telefax No.:	AME or eye specialist stamp with No.:

INSTRUCTIONS FOR COMPLETION OF THE OPHTHALMOLOGY EXAMINATION REPORT FORM

Writing should be legible and in block capitals using a ball-point pen. Completion of this form by typing or printing is also acceptable. If more space is required to answer any question, a plain sheet of paper should be used, bearing the applicant's name, the name and signature of the AME or ophthalmology specialist performing the examination and the date of signing. The following numbered instructions apply to the numbered headings on the ophthalmology examination report form.

Failure to complete the medical examination report form in full, as required, or to write legibly may result in non-acceptance of the application in total and may lead to withdrawal of any medical certificate issued. The making of false or misleading statements or the withholding of relevant information by an examiner may result in criminal prosecution, denial of an application or withdrawal of any medical certificate granted.

The AME or ophthalmology specialist performing the examination should verify the identity of the applicant. The applicant should then be requested to complete the sections 1, 2, 3, 4, 5, 6, 7, 12 and 13 on the form and then sign and date the consent to release of medical information (section 301) with the examiner countersigning as witness.

302 EXAMINATION CATEGORY – Tick appropriate box.

Initial – Initial examination for either class 1 or 2; also initial examination for upgrading from class 2 to 1 (~~notate~~ insert 'upgrading' in section 303).

Renewal/Revalidation – Subsequent comprehensive ophthalmological examinations (due to refractive error).

Special referral – NON-ROUTINE examination for assessment of an ophthalmological symptom or finding.

303 OPHTHALMOLOGICAL HISTORY – Detail here any history of note or reasons for special referral.

304 to 309 inclusive: CLINICAL EXAMINATION – These sections together cover the general clinical examination and each of the sections should be marked (with a tick) as normal or abnormal. Any abnormal findings or comments on findings should be entered in section 321.

310 CONVERGENCE – Enter near point of convergence in cm, as measured using RAF near point rule or equivalent. Tick whether normal or abnormal. Any abnormal findings or comments on findings should be entered in section 321.

311 ACCOMMODATION – Enter measurement recorded in dioptres using RAF near point rule or equivalent. Tick whether normal or abnormal. Any abnormal findings or comments on findings should be entered in section 321.

312 OCULAR MUSCLE BALANCE – Ocular muscle balance is tested at distant 5 or 6 m and near at 30-50 cm and results recorded. Presence of tropia or phoria must be entered accordingly and also whether fusional reserve testing was NOT performed and if performed whether normal or not.

313 COLOUR PERCEPTION – Enter type of pseudo-isochromatic plates (Ishihara) as well as number of plates presented with number of errors made by examinee. 15 plates should normally be presented from the 24-plate series, in random order. State whether advanced colour perception testing is indicated and what methods used (~~which colour lantern~~ CAD or anomaloscopy) and finally whether judged to be colour safe or unsafe. Advanced colour perception testing is usually only required for initial assessment, unless indicated by change in applicant's colour perception. Class 3 applicants are required to demonstrate normal trichromacy which cannot be done by using only pseudo-isochromatic plates, therefore, in their case, advanced colour perception testing is needed as default at the initial examination or whenever there is a clinical indication.

314–316 VISUAL ACUITY TESTING AT 5 m/6 m, 1 m and 30-50 cm – Record actual visual acuity obtained in appropriate boxes. If correction not worn nor required, put line through corrected vision boxes. Distant visual acuity to be tested at either 5 m or 6 m with the appropriate chart for that distance.

317 REFRACTION – Record results of refraction. Indicate also whether for class 2 applicants, refraction details are based upon spectacle prescription.

318 SPECTACLES – Tick appropriate box signifying if spectacles are or are not worn by applicant. If used, state whether unifocal, bifocal, varifocal or look-over.

319 CONTACT LENSES – Tick appropriate box signifying if contact lenses are or are not worn. If worn, state type from the following list; hard, soft, gas-permeable, disposable.

320 INTRA-OCULAR PRESSURE – Enter intra-ocular pressure recorded for right and left eyes and indicate whether normal or not. Also indicate method used – applanation, air etc.

321 OPHTHALMOLOGICAL REMARKS AND RECOMMENDATION – Enter here all remarks, abnormal findings and assessment results. Also enter any limitations recommended. If there is any doubt about findings or recommendations, the examiner may contact the ~~AMS~~ medical assessor of the licensing authority for advice before finalising the report form.

322 OPHTHALMOLOGY EXAMINER'S DETAILS – The ophthalmology examiner must sign the declaration, complete ~~his/her~~ his or her name and address in block capitals, contact details and lastly stamp the report with ~~his/her~~ his or her designated stamp incorporating ~~his/her~~ his or her AME or specialist number.

323 PLACE AND DATE – Enter the place (town or city) and the date of examination. The date of examination is the date of the clinical examination and not the date of finalisation of form. If the ophthalmology examination report is finalised on a different date, enter date of finalisation on section 321 as 'Report finalised on .....'.

OTORHINOLARYNGOLOGY (ENT) EXAMINATION REPORT FORM

Complete this page fully and in block capitals – Refer to instructions for completion.

MEDICAL IN CONFIDENCE

Applicant's details

(1) State applied to:	(2) Medical certificate applied for: class 1 ☐ class 2 ☐ class 3 ☐		(12) Application: Initial ☐ Revalidation/Renewal ☐
(3) Surname:	(4) Previous surname(s):		
(5) Forename(s):	(6) Date of birth:	(7) Sex: Male ☐ Female ☐	(13) Reference number:

(401) ~~Consent to release of medical information:~~ I hereby ~~authorise the release of~~ declare that I have been informed and I understand that all information provided to my AME, contained in this report and ~~any or all~~ its attachments ~~to the AME and, where necessary~~, may be released to the medical assessor of the my licensing authority and to the medical assessor of the competent authority of my AME, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and for oversight purposes ~~will become and remain the property of the licensing authority~~, providing that I or my physician may have access to them ~~according to~~ in accordance with national law. Medical confidentiality will be respected at all times.

---------- Date ---------- Signature of applicant ~~Signature of AME~~

(402) Examination category:

Initial ☐
Special referral ☐

(403) Otorhinolaryngological (ENT) history:

Clinical examination

Check each item	Normal	Abnormal
(404) Head, face, neck, scalp		
(405) Buccal cavity, teeth		
(406) Pharynx		
(407) Nasal passages and naso-pharyn~~n~~x (incl. anterior rhinoscopy)		
(408) Vestibular system incl. Romberg test		
(409) Speech		
(410) Sinuses		
(411) Ext acoustic meati, tympanic membranes		
(412) Pneumatic otoscopy		
(413) ~~Impedance t~~Tympanometry including Valsalva m~~e~~anoeuvre (initial~~only~~ or if clinically indicated)		

(419) *Pure tone audiometry*

dB HL (hearing level)

Hz	Right ear	Left ear
250		
500		
1000		
2000		
3000		
4000		
6000		
8000		

(420) *Audiogram*

o = Right – – – = Air
x = Left ..... = Bone

dB/HL								
–10								
0								
10								
20								
30								
40								
50								
60								
70								
80								
90								
100								
110								
120								
Hz	250	500	1000	2000	3000	4000	6000	8000

Additional testing (if indicated)	Not performed	Normal	Abnormal
(414) Speech ~~audiometry~~ discrimination test with/without hearing aids, as applicable			
(415) Posterior rhinoscopy			
(416) E~~O~~NG; spontaneous and positional nystagm~~u~~s			
(417) ~~Differential c~~Caloric test or vestibular ~~auto~~rotation test			
(418) Mirror or fibre laryngoscopy			

(421) **Otorhinolaryngology remarks~~and recommendation~~:**

(422) **Examiner's declaration:**

I hereby certify that I~~/my AME group~~ have personally examined or assessed the ENT specialist's examination report of the applicant named ~~o~~in this medical examination report and that this report with any attachment embodies ~~my~~ the findings completely and correctly.

(423) Place and date:	~~ORL examiner's~~ ~~n~~Name and address: (block capitals)	AME or ENT specialist stamp with No:
AME or ENT specialist signature:	E-mail: Telephone No.: Telefax No.:	

INSTRUCTIONS FOR COMPLETION OF THE OTORHINOLARYNGOLOGY (ENT) EXAMINATION REPORT FORM

Writing should be legible and in block capitals using a ball-point pen. Completion of this form by typing or printing is also acceptable. If more space is required to answer any question, a plain sheet of paper should be used, bearing the applicant's name, the name and signature of the AME or otorhinolaryngology specialist performing the examination and the date of signing. The following numbered instructions apply to the numbered headings on the otorhinolaryngology examination report form.

Failure to complete the medical examination report form in full, as required, or to write legibly may result in non-acceptance of the application in total and may lead to withdrawal of any medical certificate issued. The making of false or misleading statements or the withholding of relevant information by an examiner may result in criminal prosecution, denial of an application or withdrawal of any medical certificate granted.

The AME or otorhinolaryngology specialist performing the examination should verify the identity of the applicant. The applicant should then be requested to complete the sections 1, 2, 3, 4, 5, 6, 7, 12 and 13 on the form and then sign and date the consent to release of medical information (section 401) with the examiner countersigning as witness.

402 EXAMINATION CATEGORY – Tick appropriate box.

Initial – Initial examination for class 1; also initial examination for upgrading from class 2 to 1 (~~notate~~ insert 'upgrading' in section 403)

Special Referral – NON-ROUTINE examination for assessment of an ORL (ENT) symptom or finding

403 OTORHINOLARYNGOLOGICAL (ENT) HISTORY – Detail here any history of note or reasons for special referral.

404-413 inclusive: CLINICAL EXAMINATION – These sections together cover the general clinical examination and each of the sections should be marked (with a tick) as normal or abnormal. Any abnormal findings or comments on findings should be entered in section 421.

414-418 inclusive: ADDITIONAL TESTING – These tests are only required to be performed if indicated by history or clinical findings and are not routinely required. For each test one of the boxes must be completed – if the test is not performed then tick that box – if the test has been performed then tick the appropriate box for a normal or abnormal result. All remarks and abnormal findings should be entered in section 421.

419 PURE TONE AUDIOMETRY – Complete figures for dB HL (hearing level) in each ear at all listed frequencies.

420 AUDIOGRAM – Complete audiogram from figures as listed in section 419.

421 OTORHINOLARYNGOLOGY (ENT) REMARKS AND RECOMMENDATION – Enter here all remarks, abnormal findings and assessment results. Also enter any limitations recommended. If there is any doubt about findings or recommendations the examiner may contact the ~~AMS~~ medical assessor of the licensing authority for advice before finalising the report form.

422 OTORHINOLARYNGOLOGY (ENT) EXAMINER'S DETAILS – The otorhinolaryngology (ENT) examiner must sign the declaration, complete ~~his/her~~ his or her name and address in block capitals, contact details and lastly stamp the report with ~~his/her~~ his or her designated stamp incorporating ~~his/her~~ his or her AME or specialist number.

423 PLACE AND DATE – Enter the place (town or city) and the date of examination. The date of examination is the date of the clinical examination and not the date of finalisation of form. If the ORL (ENT) examination report is finalised on a different date, enter date of finalisation in section 421 as 'Report finalised on .....'.

Rationale *RMT.0287*

The rulemaking group identified the need to make certain updates to the aero-medical forms templates to match the updates to the implementing rules. Furthermore, the need was identified to update the instructions for filling in the forms to keep them fit for purpose.

Consequently, the rulemaking group proposed the updates to the GM containing the ophthalmology and otorhinolaryngology examination report forms and the applicable instructions above.

AMC1 ARA.MED.150(f) Record-keeping

REPORTING HEALTH DATA OF PILOTS ABOVE THE AGE OF 60

For pilots above the age of 60 the competent authorities performing the analysis of health data should report in an aggregated manner to EASA at least the following data:

(a) number and proportion of pilots above the age of 60 assessed as unfit, as well as the most common medical conditions that triggered unfitness and the age distribution;

(b) proportion of incapacitation (partial and total) events among this category of pilots and the most common medical and, if applicable, the operational conditions that triggered incapacitation;

(c) the proportion of pilots above the age of 60 who did not revalidate their medical certificate;

(d) any safety concerns based on the trends identified as a result of the data analysis.

Rationale *RMT.0287*

The EASA study on pilot age, the consultation sessions related to Subtask 2b and the discussions in the MEG highlighted the importance of having reliable data related the pilot health status by age groups. This is especially important in the context of the discussions on pilot age limits.

Consequently, the rulemaking group of Subtask 2b proposed to add a new AMC to detail the means of compliance related to the new requirement of ARA.MED.150(f) clarifying the minimum data that should be reported.

SECTION II — AERO-MEDICAL EXAMINERS (AMEs)

AMC1 ARA.MED.200 Procedure for the issue, revalidation, renewal or change of an AME certificate

INSPECTION OF THE AME PRACTICE

~~Before issuing the~~ Upon request for issue, revalidation, renewal or change of an AME certificate, the competent authority should conduct an inspection of the AME practice to verify compliance with point ARA.MED.200~~(a)~~.

For applicants for an AME certificate with the privileges of class 2 medical certification only, a virtual inspection of the AME premises may be acceptable. In case of concerns regarding compliance with this Regulation, an on-site inspection should be conducted.

Rationale *RMT.0287*

Following the discussions in the MEG, the rulemaking group agreed, considering the geographical spread of AMEs and limited resources of the competent authorities, that it would be beneficial to enable the possibility of having virtual inspections of the AME practices in the case of class 2 AME certificates.

Consequently, the rulemaking group proposed to add another paragraph to the text of AMC1 ARA.MED.200 enabling this possibility.

AMC2 ARA.MED.200 Procedure for the issue, revalidation, renewal or change of an AME certificate

~~The competent authority should implement a procedure to ensure, before revalidation, renewal or extension of privileges of an AME certificate, that applicants retain their level of aero-medical competency.~~

The competent authority should implement a procedure to verify:

(a) for the initial issue or extension of an AME certificate, evidence of successful completion of an approved aviation medicine training course in accordance with the privileges of the AME certificate applied for;

(b) for revalidation and renewal of an AME certificate, evidence of refresher training and maintenance of aero-medical competency.

Rationale *RMT.0287*

The rulemaking group and the discussions in the MEG highlighted the fact that the content of AMC2 ARA.MED.200 was adding a new requirement and is more suitable to be in the implementing rules. For this reason the previous content of this AMC has been added to the implementing rule while the

AMC2 ARA.MED.200 text has been replaced with the text above specifying the evidence that should be verified as part of the procedure to issue, revalidate, renew or change an AME certificate.

AMC1 ARA.MED.246 Cooperative oversight of AMEs and AeMCs

The cooperative oversight procedure may include oversight tasks to be undertaken by the competent authority of the Member State where the AME/AeMC has its secondary place of business.

The results of the oversight should be shared among the competent authorities of the Member States involved.

Rationale *RMT.0287*

The standardisation experience and the discussions in the MEG highlighted the importance of having in place regulatory material regarding the oversight of AMEs and AeMCs. Consequently the rulemaking group developed the implementing rule and the new AMC above to clarify the expectations regarding the cooperative oversight for AMEs or AeMCs having multiple locations in more than one Member State.

AMC1 ARA.MED.250(a) Limitation, suspension or revocation of an AME certificate

(a) The competent authority should consider, as part of the assessment of compliance, the compliance with the applicable implementing rules and acceptable means of compliance, as well as the national procedures in place to implement the respective requirements.

(b) The competent authority should consider the level of aero-medical competency as one of the criteria for continuing certification.

Rationale *RMT.0287*

The standardisation experience and the discussions taking place during the MEG highlighted difficulties in the legal interpretation of the implementing rules and means to comply with these implementing rules regarding what can be considered compliant with applicable requirements or meeting the criteria for continuing certification.

Consequently, the rulemaking group proposed the clarification of the wording of the implementing rule and the development of a new AMC to clarify the expectation related to AME compliance and the criteria for continuing certification.

SECTION III — MEDICAL CERTIFICATION

AMC1 ARA.MED.315(a) Review of examination reports

GENERAL

(a) The process to review examination and assessment reports received from AeMCs, AMEs and GMPs should aim to check all reports ~~received~~.

(b) The aero-medical section of the licensing authority should implement a performance assessment process for AMEs to ~~should~~ take account of the proportion of inconsistencies or errors found~~in the assessment process and~~, adapt the sample size accordingly and consider corrective action(s) ~~to review all reports if necessary~~.

(c) The aero-medical section of the licensing authority should implement a medical review process of all examination and assessment reports received from AeMCs, AMEs and GMPs certified by the competent authority of another Member State.

Rationale	*RMT.0287*
The rulemaking group and the discussions in the MEG highlighted the importance of taking mitigating action in case of inconsistencies and errors discovered during the review of files. This is even more important for medical certificates issued by AeMCs, AMEs or GMPs that are under the oversight of a different competent authority as these files are likely to escape the continuous oversight activities of those competent authorities. In this context, this AMC is updated to provide clear information regarding the intention and meaning of the review of medical files provisions and a new point has been added recommending licensing authorities to review all medical files received from AeMCs, AMEs and GMPs certified by the competent authority of another Member State.	

AMC1 ARA.MED.325 Secondary review procedure

(a) The secondary review procedure should specify:

(1) the establishment of a review board and its composition;

(2) how potential conflict of interest should be managed;

(3) how the accredited medical conclusions of the review board will be implemented.

(b) The composition of the review board should be decided by the aero-medical section of the licensing authority. It may be preceded by the advice of the medical assessor and may consist of, but not be limited to:

(1) clinical medical experts according to the case;

(2) other technical experts according to the case;

(3) aviation medicine experts;

(4) AME(s) with privileges according to the class on the medical certificate in question, other than the AME(s) involved in the assessment of the fitness of the applicant.

Rationale	*RMT.0287*
The rulemaking group and the discussions in the MEG highlighted the importance of having some details on means of compliance with the requirements related to secondary review, namely the review board and its composition and how the medical conclusion of the review board will be implemented. Considering the contentious potential of the secondary review, the rulemaking group considered that having a secondary review board will provide an independent accredited medical conclusion giving proper consideration to technical and operational aspects. Consequently, the rulemaking group proposed to add this new AMC related to secondary review procedure.	

~~AMC1 ARA.MED.330 Special medical circumstances~~

~~**GENERAL**~~

~~The protocol should:~~

~~(a) assess the incapacitation risk~~

~~(b) assess the risk of subtle impairment of performance;~~

~~(c) undertake a risk-benefit analysis;~~

~~(d) include a review of the regulations in use in other major aviation states and ICAO;~~

~~(e) determine which class of medical certificate is included in the scope;~~

~~(f) estimate the number of pilots likely to be included;~~

~~(g) list all anticipated risks to the protocol and provide a risk management strategy including appropriate limitations for every anticipated risk. Where the risk of subtle impairment of performance is identified, the protocol should include requirements for minimum simulator testing or minimum line flying under supervision or both.~~

~~(h) nominate medical research experts, if necessary, to provide advice on research methods.~~

~~AMC1 ARA.MED.330(b)(c) Special medical circumstances~~

~~**GENERAL**~~

~~Initial medical certificates issued on the basis of a research protocol should only be issued by the competent authority. Thereafter, the competent authority should decide whether the AeMC or AME may issue the medical certificate.~~

~~GM1 ARA.MED.330 Special medical circumstances~~

~~**GENERAL**~~

~~(a) When the terms 'medical assessment protocol', 'research protocol' and 'protocol' (as mentioned in ARA.MED.330 and its associated AMC) are used, they all refer to a 'medical assessment protocol'.~~

~~(b) The protocol is to enable experience to be gained on special medical circumstances in a controlled manner. This is to facilitate a better understanding of the treatment or condition, so that an evidence-based decision concerning its implementation may be considered.~~

~~(c) The protocol and its implementation should comply with the principles described in the following publication by the World Medical Association (WMA): 'WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects', as last amended.~~

Rationale *RMT.0287*

As a result of the discussions that took place during the MEG meetings regarding the provisions of point ARA.MED.330, and based on the assessment of the rulemaking group, it was revealed that there is a need to amend point ARA.MED.330, as it does not comply with the criteria for medical research protocols especially in terms of objectivity and ethical principles. During the NPA consultation, a large number of comments were received from Member States and industry requesting that point ARA.MED.330 and corresponding AMC/GM be deleted as, in addition to the justification mentioned above, this IR does not comply with the aviation safety principles. As a result, the MEG was consulted again regarding the deletion of point ARA.MED.330 and the vast majority of the MEG members were in favour of deleting point ARA.MED.330. Considering the current EASA research project on diabetes mellitus, the MEG members also agreed to allow the current protocol established under point ARA.MED.330 to continue until the defined end date in order to have no impact on the licence holders enrolled in the protocol.