CABIN CREW PERIODIC MEDICAL ASSESSMENT IN ACCORDANCE WITH EU-OPS 1.995

Complete this form fully using a black ball point pen and in block captials

MEDICAL IN CONFIDENCE

Surname:	**Previous surname(s):**	Title:	**Crew Code**
First Name:	**Date of birth:** D D M M Y Y Y Y	**Male** ☐	**Female** ☐
Place and country of birth:	Nationality:		
Address: **Postcode:** **Country:**	**Medical examiner/ Practitioner Name:** **Address:**		
Telephone No:	**Telephone No:**		
Mobile No:	**Email Address:**		

Alcohol – state average weekly intake in units:	Do you currently use any medication? Yes ☐ No ☐ If YES, state name of medication, dose, date started and why
Do you smoke tobacco? Never smoked ☐ Yes ☐ No ☐ If no, date stopped: M M Y Y Y Y	M M Y Y Y Y M M Y Y Y Y M M Y Y Y Y

Since your last medical assessment have you:

	YES	NO
1. Remained in good health?		
2. Developed any medical condition or had treatment for any illness not declared at a previous medical assessment?		
3. Noticed any deterioration of distant or close vision?		
4. Been prescribed glasses or contact lenses?		
5. Noticed any deterioration of hearing?		
6. Had any ear, nose, sinus or throat problem?		
If you have ticked YES for any of the questions please give details:		

Declaration: I hereby declare that I have carefully considered the statements made above and that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement.

Signature: ……… Date: ………………………………………