

## Instructions for Completion of the Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate, FAA Form 8500-8

**Applicant** must fill in completely numbers 1 through 20 of the application using a ballpoint pen. Exert sufficient pressure to make legible copies. The following numbered instructions apply to the numbered headings on the application form that follows this page.

**NOTICE** -- Intentional falsification may result in federal criminal prosecution. Intentional falsification may also result in suspension or revocation of all airman, ground instructor, and medical certificates and ratings held by you, as well as denial of this application for medical certification.

- 1. APPLICATION FOR** -- Check the appropriate box.
- 2. CLASS OF AIRMAN MEDICAL CERTIFICATE APPLIED FOR** -- Check the appropriate box for the class of airman medical certificate for which you are making application.

**3. FULL NAME** -- If your name has changed for any reason, list current name on the application and list any former name(s) in the EXPLANATIONS box of number 18 on the application.

**4. SOCIAL SECURITY NUMBER** -- The social security number is optional; however, its use as a unique identifier does eliminate mistakes.

**5. ADDRESS** -- Give permanent mailing address and country. Include your complete nine digit ZIP code if known. Provide your current area code and telephone number.

**6. DATE OF BIRTH** -- Specify month (MM), day (DD), and year (YYYY) in numerals; e.g., 01/31/1950. Indicate citizenship; e.g., U.S.A.

**7. COLOR OF HAIR** -- Specify as brown, black, blond, gray, or red. If bald, so state. Do not abbreviate.

**8. COLOR OF EYES** -- Specify actual eye color as brown, black, blue, hazel, gray, or green. Do not abbreviate.

**9. SEX** -- Indicate male or female.

**10. TYPE OF AIRMAN CERTIFICATE(S) YOU HOLD** -- Check applicable block(s). If "Other" is checked, provide name of certificate.

**11. OCCUPATION** -- Indicate major employment. "Pilot" will be used only for those gaining their livelihood by flying.

**12. EMPLOYER** -- Provide your employer's full name. If self-employed, so state.

**13. HAS YOUR FAA AIRMAN MEDICAL CERTIFICATE EVER BEEN DENIED, SUSPENDED, OR REVOKED** -- If "yes" is checked, give month and year of action in numerals.

**14. TOTAL PILOT TIME TO DATE** -- Give total number of civilian flight hours. Indicate whether logged or estimated. Abbreviate as Log. or Est.

**15. TOTAL PILOT TIME PAST 6 MONTHS** -- Give number of civilian flight hours in the 6-month period immediately preceding date of this application. Indicate whether logged or estimated. Abbreviate as Log. or Est.

**16. MONTH AND YEAR OF LAST FAA MEDICAL EXAMINATION** -- Give month and year in numerals. If none, so state.

**17a. DO YOU CURRENTLY USE ANY MEDICATION (Prescription or Nonprescription)** -- Check "yes" or "no." If "yes" is checked, give name of medication(s) and indicate if the medication was listed in a previous FAA medical examination. See **NOTE** below.

**17b.** Indicate whether you use near vision contact lens(es) while flying.

**18. MEDICAL HISTORY** -- Each item under this heading must be checked either "yes" or "no." You must answer "yes" for every condition you have ever been diagnosed with, had, or presently have and describe the condition and approximate date in the EXPLANATIONS block.

If information has been reported on a previous application for airman medical certificate and there has been no change in your condition, you may note "PREVIOUSLY REPORTED, NO CHANGE" in the EXPLANATIONS box, but you must still check "yes" to the condition. Do not report occasional common illnesses such as colds or sore throats.

"Substance dependence" is defined by any of the following: increased tolerance; withdrawal symptoms; impaired control of use; or continued use despite damage to health or impairment of social, personal, or occupational functioning. "Substance abuse" includes the following: use of an illegal substance; use of a substance or substances in situations in which such use is physically hazardous; or misuse of a substance when such misuse has impaired health or social or occupational functioning. "Substances" include alcohol, PCP, marijuana, cocaine, amphetamines, barbiturates, opiates, and other psychoactive chemicals.

Conviction and/or Administrative Action History -- Letter (v) of this subheading asks if you have ever been: (1) convicted (which may include paying a fine, or forfeiting bond or collateral) of an offense involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) convicted or subject to an administrative action by a state or other jurisdiction for an offense for which your license was denied, suspended, cancelled, or revoked or which resulted in attendance at an educational or rehabilitation program. Individual traffic convictions are not required to be reported if they did not involve: alcohol or a drug; suspension, revocation, cancellation, or denial of driving privileges; or attendance at an educational or rehabilitation program. If "yes" is checked, a description of the conviction(s) and/or administrative action(s) must be given in the EXPLANATIONS box. The description must include: (1) the alcohol or drug offense for which you were convicted or the type of administrative action involved (e.g., attendance at an alcohol treatment program in lieu of conviction; license denial, suspension, cancellation, or revocation for refusal to be tested; educational safe driving program for multiple speeding convictions; etc.); (2) the name of the state or other jurisdiction involved; and (3) the date of the conviction and/or administrative action. The FAA may check state motor vehicle driver licensing records to verify your responses. Letter (w) of this subheading asks if you have ever had any other (nontraffic) convictions (e.g., assault, battery, public intoxication, robbery, etc.). If so, name the charge for which you were convicted and the date of conviction in the EXPLANATIONS box. See **NOTE** below.

**19. VISITS TO HEALTH PROFESSIONAL WITHIN LAST 3 YEARS** -- List all visits in the last 3 years to a physician, physician assistant, nurse practitioner, psychologist, clinical social worker, or substance abuse specialist for treatment, examination, or medical/mental evaluation. List visits for counseling only if related to a personal substance abuse or psychiatric condition. Give date, name, address, and type of health professional consulted and briefly state reason for consultation. Multiple visits to one health professional for the same condition may be aggregated on one line. Routine dental, eye, and FAA periodic medical examinations and consultations with your employer-sponsored employee assistance program (EAP) may be excluded unless the consultations were for your substance abuse or unless the consultations resulted in referral for psychiatric evaluation or treatment. See **NOTE** below.

**20. APPLICANT'S DECLARATION** -- Two declarations are contained under this heading. The first authorizes the National Driver Register to release adverse driver history information, if any, about the applicant to the FAA. The second certifies the completeness and truthfulness of the applicant's responses on the medical application. The declaration section must be signed and dated by the applicant after the applicant has read it.

**NOTE:** If more space is required to respond to "yes" answers for numbers 17, 18, or 19, use a plain sheet of paper bearing the information, your signature, and the date signed.

**Applicant -- Please Tear Off This Sheet After Completing The Application Form.**

**Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT**

Form Approved OMB NO. 2120-0034

Copy of FAA Form 8500-8 (Medical Certificate) or FAA Form B420-2 Medical/Student Pilot Certificate) issued.

**FF- 1953420**

**MEDICAL CERTIFICATE CLASS AND STUDENT PILOT CERTIFICATE**

This certifies that(Full name and address):

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination: \_\_\_\_\_ Examiner's Designation No. \_\_\_\_\_

Examiner Signature: \_\_\_\_\_  
Typed Name: \_\_\_\_\_

**AIRMAN'S SIGNATURE**

1. Application For:  
 Airman Medical Certificate     Airman Medical and Student Pilot Certificate

2. Class of Medical Certificate Applied For:  
 1st     2nd     3rd

3. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

4. Social Security Number \_\_\_\_\_

5. Address \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

Number / Street \_\_\_\_\_  
City \_\_\_\_\_ State / Country \_\_\_\_\_ Zip Code \_\_\_\_\_

6. Date of Birth \_\_\_\_\_ M M / D D / Y Y Y Y    7. Color of Hair \_\_\_\_\_    8. Color of Eyes \_\_\_\_\_    9. Sex \_\_\_\_\_

Citizenship \_\_\_\_\_

10. Type of Airman Certificate(s) You Hold:  
 None     ATC Specialist     Flight Instructor     Recreational  
 Airline Transport     Flight Engineer     Private     Other  
 Commercial     Flight Navigator     Student

11. Occupaton \_\_\_\_\_    12. Employer \_\_\_\_\_

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked?  
 Yes     No    If yes, give date \_\_\_\_\_ M M / D D / Y Y Y Y

Total Pilot Time (Civilian Only)  
 14. To Date \_\_\_\_\_    15. Past 6 months \_\_\_\_\_    16. Date of Last FAA Medical Application \_\_\_\_\_ M M / D D / Y Y Y Y     No Prior Application

17a. Do You Currently Use Any Medication (Prescription or Nonprescription)?  
 No     Yes (If yes, below list medication(s) used and check appropriate box).    **Previously Reported**

	Yes	No
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

(If more space is required, see 17.a. on the instruction sheet).

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying?     Yes     No

**18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING?** Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. **See instructions Page**

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a. <input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches	g. <input type="checkbox"/>	<input type="checkbox"/>	Heart or vascular trouble	m. <input type="checkbox"/>	<input type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.	r. <input type="checkbox"/>	<input type="checkbox"/>	Military medical discharge
b. <input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spell	h. <input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	n. <input type="checkbox"/>	<input type="checkbox"/>	Substance dependence or failed a drug test ever, or substance abuse or use of illegal substance in the last 2 years.	s. <input type="checkbox"/>	<input type="checkbox"/>	Medical rejection by military service
c. <input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness for any reason	i. <input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	o. <input type="checkbox"/>	<input type="checkbox"/>	Alcohol dependence or abuse	t. <input type="checkbox"/>	<input type="checkbox"/>	Rejection for life or health insurance
d. <input type="checkbox"/>	<input type="checkbox"/>	Eye or vision trouble except glasses	j. <input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	p. <input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	u. <input type="checkbox"/>	<input type="checkbox"/>	Admission to hospital
e. <input type="checkbox"/>	<input type="checkbox"/>	Hay fever or allergy	k. <input type="checkbox"/>	<input type="checkbox"/>	Diabetes	q. <input type="checkbox"/>	<input type="checkbox"/>	Motion sickness requiring medication	x. <input type="checkbox"/>	<input type="checkbox"/>	Other illness, disability, or surgery
f. <input type="checkbox"/>	<input type="checkbox"/>	Asthma or lung disease	l. <input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.						

**Conviction and/or Administrative Action History — See Instructions Page**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of nontraffic conviction(s) (misdemeanors or felonies).
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Explanations: **See Instructions Page**

**FOR FAA USE**  
Review Action Codes

**19. Visits to Health Professional Within Last 3 Years.**     Yes (Explain Below)     No    **See Instructions Page**

Date	Name, Address, and Type of Health Professional Consulted	Reason

**— NOTICE —**

Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to \$250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Secs. 1001; 3571)

**20. Applicant's National Driver Register and Certifying Declarations**

I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S. Code 401, Note.

**NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.**

I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

M M / D D / Y Y Y Y

**NOTE: FAA/Original Copy of the Report of Medical Examination Must Be TYPED.**

REPORT OF MEDICAL EXAMINATION															
21. Height (inches)		22. Weight (pounds)		23. Statement of Demonstrated Ability (SODA) G Yes                      G No                      Defect Noted:						24. SODA Serial Number					
CHECK EACH ITEM IN APPROPRIATE COLUMN				Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN				Normal	Abnormal				
25. Head, face, neck, and scalp						37. Vascular system (Pulse, amplitude and character; arms, legs, others)									
26. Nose						38. Abdomen and viscera (Including hernia)									
27. Sinuses						39. Anus (Not including digital examination)									
28. Mouth and throat						40. Skin									
29. Ears, general (Internal and external canals; Hearing under item 49)						41. G-U system (Not including pelvic examination)									
30. Ear Drums (Perforation)						42. Upper and lower extremities (Strength and range of motion)									
31. Eyes, general (Vision under items 50 to 54)						43. Spine, other musculoskeletal									
32. Ophthalmoscopic						44. Identifying body marks, scars, tattoos (Size and location)									
33. Pupils (Equality and reaction)						45. Lymphatics									
34. Ocular motility (Associated parallel movement, nystagmus)						46. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)									
35. Lungs and chest (Not including breast examination)						47. Psychiatric (Appearance, behavior, mood, communication, and memory)									
36. Heart (Precordial activity, rhythm, sounds, and murmurs)						48. General systemic									
<b>NOTES:</b> Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.															
49. Hearing		Record Audiometric Speech Discrimination Score Below		Right Ear						Left Ear					
Conversational Voice Test at 6 Feet G Pass    G Fail				Audiometer Threshold in Decibels		500	1000	2000	3000	4000	500	1000	2000	3000	4000
50. Distant Vision				51.a. Near Vision				51.b. Intermediate Vision – 32 Inches				52. Color Vision			
Right	20/	Corrected to 20/		Right	20/	Corrected to 20/		Right	20/	Corrected to 20/		G Pass			
Left	20/	Corrected to 20/		Left	20/	Corrected to 20/		Left	20/	Corrected to 20/		G Fail			
Both	20/	Corrected to 20/		Both	20/	Corrected to 20/		Both	20/	Corrected to 20/					
53. Field of Vision			54. Heterophoria 20' (in prism diopters)				Esophoria		Expophoria		Right Hyperphoria		Left Hyperphoria		
G Normal      G Abnormal															
55. Blood Pressure			56. Pulse (Resting)		57. Urinalysis (if abnormal, give results)				58. ECG (Date)						
(Sitting, mm of Mercury)		Systolic	Diastolic			G Normal      G Abnormal				Albumin	Sugar	MM	DD	YYYY	
59. Other Tests Given															
60. Comments on History and Findings: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.)											<b>FOR FAA USE</b>				
											<b>Pathology Codes:</b>				
											<b>Coded By:</b>				
											<b>Clerical Reject</b>				
Significant Medical History			G YES      G NO		Abnormal Physical Findings				G YES      G NO						
61. Applicant's Name					62. Has Been Issued -- G Medical Certificate      G Medical & Student Pilot Certificate G No Certificate Issued -- Deferred for Further Evaluation G Has Been Denied -- Letter of Denial Issued (Copy Attached)										
63. Disqualifying Defects (List by item number)															
64. Medical Examiner's Declaration -- I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.															
Date of Examination			Aviation Medical Examiner's Name						Aviation Medical Examiner's Signature						
M M   D D   Y Y Y Y			Street Address												
			City						AME Serial Number						
			State						AME Telephone (      )						