



U.S. Department
of Transportation
Federal Aviation
Administration

INFORMATION FOR APPLICANT

Application For Airman Medical Certificate or Airman Medical and Student Pilot Certificate

Privacy Act Statement

The information on the attached FAA Form 8500-8, Application For Airman Medical Certificate or Airman Medical and Student Pilot Certificate, is solicited under the authority of Title 49, United States Code (U.S.C.) (Transportation) sections 109(9), 40113(a), 44701-44703, and 44709 (1994) formerly codified in the Federal Aviation Act of 1958, as amended, and Title 14, Code of Federal Regulations (CFR), part 67, Medical Standards and Certification.

Except for your Social Security Number (SSN), submission of this information is mandatory. Incomplete submission will result in delay of further consideration or denial of your application for a medical certificate or medical and student pilot certificate. Other than your SSN, the purpose of the information is to determine whether you meet Federal Aviation Administration (FAA) medical requirements to hold a medical certificate or medical and student pilot certificate. The information will also be used to provide data for the FAA's automated medical certification system to depict airman population patterns and to update certification procedures and medical standards. For air traffic control specialists (ATCS) employed by the Federal Government, the information requested will be used as a basis for determining medical eligibility for initial and continuing employment. The information becomes part of the FAA Privacy Act system of records, DOT/FAA-847, General Air Transportation Records on Individuals. These records and information in these records may be used (a) to provide basic airman certification and qualification information to the public upon request; (b) to disclose information to the National Transportation Safety Board (NTSB) in connection with its investigation responsibilities; (c) to provide information about airmen to Federal, state, and local law enforcement agencies when engaged in the investigation and apprehension of drug law violators; (d) to provide information about enforcement actions arising out of violations of the Federal Aviation Regulations to government agencies, the aviation industry, and the public upon request; (e) to disclose information to another Federal agency, or to a court or an administrative tribunal, when the Government or one of its agencies is a party to a judicial proceeding before the court or involved in administrative proceedings before the tribunal; and (f) to comply with the Prefatory Statement of General Routine Uses for the Department of Transportation.

Submission of your SSN is not required by law and is voluntary. Refusal to furnish your SSN will not result in the denial of any right, benefit, or privilege provided by law. Your SSN is solicited to assist in performing the agency's functions under 49 U.S.C. (Transportation). If supplied, it will be used by the FAA to associate all information in agency files relating to you. If you refuse to supply your SSN, a substitute number or other identifier will be assigned, as required.

The written consent authorization of this form under No. 20, Applicant's Declaration, permits the FAA to request information, if any, pertaining to your driving record from the National Driver Register (NDR). The FAA will then match such NDR information with the information you provide on the medical history part of the form. Since the NDR identifies only probable matches, the FAA will verify the NDR information it receives with the state of record. You have the right to request an NDR file check to determine if it contains any information and, if so, the accuracy of such information. Notarized requests may be sent to: DOT/NHTSA/NTS-32, 400 7th Street, S.W., Washington, DC 20590-0001, and must contain your complete name and date of birth. Other information about height, weight, and eye color will ensure correct positive identification.

Paperwork Reduction Act Statement:

The information collected on this form is necessary to ensure applicants meet the minimum requirements as set forth under the authority of 49 U.S.C. (Transportation). This information will be used to determine applicant eligibility for a medical certificate, medical and student pilot certificate, or ATCS eligibility for employment. When all requirements have been met, an appropriate medical certificate, medical and student pilot certificate, or medical clearance will be issued. It is estimated that it will take each applicant 2 hours to complete this form and provide all the information called for (includes providing medical history information and physical examination). The information is required to obtain a certificate and is confidential. The information will become part of the Privacy Act system of records DOT/FAA 847, General Air Transportation Records on Individuals. Note that an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this collection of information is 2120-0034.

Tear off this cover sheet before submitting this form.

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.
- 17.a. **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.
- 17.b. 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 box.
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.
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.

Copy of FAA Form 8500-8 (Medical Certificate) or FAA Form 8420-3 (Medical/Student Pilot Certificate) Issued.

FF-000000

MEDICAL CERTIFICATE CLASS AND STUDENT PILOT CERTIFICATE

This certifies that (Full name and address):

Date of Birth	Height	Weight	Hair	Eyes	Sex
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See next the medical standards prescribed in part 07, Federal Aviation Regulations, for the class of Medical Certificate

Date of Examination: _____ Examiner's Designation No. _____

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 _____ 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. Occupation _____ 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 _____
 No Prior Application

17.a. 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"/>	Frequent or severe headaches	g.	<input type="checkbox"/>	Heart or vascular trouble	m.	<input type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.	r.	<input type="checkbox"/>	Military medical discharge
b.	<input type="checkbox"/>	Dizziness or fainting spell	h.	<input type="checkbox"/>	High or low blood pressure	n.	<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"/>	Medical rejection by military service
c.	<input type="checkbox"/>	Unconsciousness for any reason	i.	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	o.	<input type="checkbox"/>	Alcohol dependence or abuse	t.	<input type="checkbox"/>	Rejection for life or health insurance
d.	<input type="checkbox"/>	Eye or vision trouble except glasses	j.	<input type="checkbox"/>	Kidney stone or blood in urine	p.	<input type="checkbox"/>	Suicide attempt	u.	<input type="checkbox"/>	Admission to hospital
e.	<input type="checkbox"/>	Hay fever or allergy	k.	<input type="checkbox"/>	Diabetes	q.	<input type="checkbox"/>	Motion sickness requiring medication	x.	<input type="checkbox"/>	Other illness, disability, or surgery
f.	<input type="checkbox"/>	Asthma or lung disease	l.	<input type="checkbox"/>	Neurological disorders: epilepsy, seizures, stroke, paralysis, etc.						

Conviction and/or Administrative Action History - See Instructions Page

Yes No	v. <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 No	w. <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) <input type="checkbox"/> YES <input type="checkbox"/> 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 & 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		

NOTES: 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 <input type="checkbox"/> Pass <input type="checkbox"/> 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/			<input type="checkbox"/> Pass			
Left 20/	Corrected to 20/	Left 20/	Corrected to 20/	Left 20/	Corrected to 20/			<input type="checkbox"/> Fail			
Both 20/	Corrected to 20/	Both 20/	Corrected to 20/	Both 20/	Corrected to 20/						
53. Field of Vision <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		54. Heterophoria 20' (in prism diopters)		Esophoria		Exophoria		Right Hyperphoria		Left Hyperphoria	
55. Blood Pressure (Sitting, mm of Mercury) <u> </u> / <u> </u> Systolic Diastolic		56. Pulse (Resting)	57. Urinalysis (if abnormal, give results) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				Albumin	Sugar		58. ECG (Date) M M D D Y Y Y Y	

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.)	FOR FAA USE
	Pathology Codes:
	Coded By:
	Clerical Reject
Significant Medical History <input type="checkbox"/> YES <input type="checkbox"/> NO Abnormal Physical Findings <input type="checkbox"/> YES <input type="checkbox"/> NO	

61. Applicant's Name	62. Has Been Issued — <input type="checkbox"/> Medical Certificate <input type="checkbox"/> Medical & Student Pilot Certificate <input type="checkbox"/> No Certificate Issued — Deferred for Further Evaluation <input type="checkbox"/> Has Been Denied — Letter of Denial Issued (Copy Attached)
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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 M M D D Y Y Y Y	Aviation Medical Examiner's Name	Aviation Medical Examiner's Signature
	Street Address	
	City State Zip Code	AME Serial Number
		AME Telephone ()