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| **CONFIDENTIAL. AME and authorised persons only.** |  |  |
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**CHECKLIST FOR MENTAL HEALTH On behalf of the U.K. Civil Aviation Authority ( adapted from EASA form)**

I would like you to fill in this form, where specified, in order that you might reflect on your mental health as it is now and since your last medical. I am sure that you will answer completely honestly and naturally understand how vital this information is for flight safety. I can assure you that any questions to which the answer is ‘Yes’ should be able to be happily resolved with no permanent loss of licence. Philip

Please complete parts 1, 2, 4 and 6. Please use BLOCK CAPITALS.

**(1) Applicant:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (1) State of licence issue: | | | | | (2) Medical certificate applied for:  Class 1 ο Class 2 ο Class 3 ο | | | | | | | |
| (3) Surname: | | | | | CAA No: | | | | | | | |
| (5) Forename(s): | | | | | (6) Date of birth: | | | | | | | |
| (7) Sex: Male / Female | | | | | (8) Place and country of birth: | | | | | | | |
| **(2)Applicant (3)AME (4)Applicant (5)AME** | | | | | | | | | | | | |
| **Review & Document** | **Y** | **N** | **Refer** | **Y** | | **N** | **Any symptoms** | | **Y** | **N** | **satisfactory** | **Y** | | **N** |
| 1  Any problems with coping strategies under periods of psychological stress or pressure in the present or past, including seeking advice from others |  |  | A  Organic mental disorder |  | |  | 5  Inappropriate use of alcohol or other psychoactive substances | |  |  | H Appearance |  | |  |
|  |  | |
| B  Psychoactive medication |  | |  | 6 Change in eating habit. /unexpected weight changes | |  |  | I  Attitude |  | |  |
| 7 Sleep problems not related to employment. | |  |  | J  Behaviour |  | |  |
| 2  *Airline or other aviators*  Any difficulties with operational crew resource management (CRM) any difficulties with employer and/or colleagues |  |  | 7  Low mood/suicidal thoughts | |  |  | K  Mood |  | |  |
|  | |
| C  Schizophrenia, schizotypal or delusional |  | |  | 8  Anger, agitation or high mood | |  |  | L  Speech |  | |  |
| D  Mood disorder |  | |  | 9  F/H of psychiatric disorders, particularly suicide | |  |  | M Thought process& content |  | |  |
| 3  Interpersonal relationship issues, including difficulties with relatives, friends and work colleagues |  |  | E Neurotic, stress – related or somatoform disorder |  | |  |
| 10 Depersonalisation or loss of control | |  |  | N  Perception |  | |  |
| F Personality or behavioural disorders |  | |  | 11 Loss of interest/energy in personal or work related activities. | |  |  | O  Cognition |  | |  |
| 4  Have you suffered with any periods of anxiety affecting behaviour or ability to cope? |  |  | G Disorders due to alcohol or other psychoactive substance or misuse |  | |  | 12 Anything else causing concern you wish to discuss, mental or physical. | |  |  | P  Insight |  | |  |
| Q  Judgement |  | |  |
| R  Deliberate self-harm and/or suicide attempt |  | |  |  | |  |  |
| Comments, Please number: | | | | | | | | | | | | | | |
| Referral to Specialist (Tick as appropriate) Yes N  Name of specialist | | | | | | | | | | | | | | |

**(6)Applicant:**

**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 all information contained in this report and any or all attachments to the AME and, where necessary, to the medical assessor of the licensing authority, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. Medical confidentiality will be respected at all times.

**Date ------------------------**

**Signature of applicant -------------------------------------------------------**

**Signature of AME/(medical assessor)--------------------------------------------------------------**

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