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.

FAA Form 8500-8 (3-99) Supersedes Previous Edition NSN: 0052-00-670-6002

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

Citizenship _____

7. Color of Hair **8. Color of Eyes** **9. Sex**

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
_____	☐	☐
_____	☐	☐
_____	☐	☐

(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. ☐	☐	Frequent or severe headaches	g. ☐	☐	Heart or vascular trouble	m. ☐	☐	Mental disorders of any sort; depression, anxiety, etc.	r. ☐	☐	Military medical discharge
b. ☐	☐	Dizziness or fainting spell	h. ☐	☐	High or low blood pressure	n. ☐	☐	Substance dependence or failed a drug test ever, or susbstance abuse or use of illegal substance in the last 2 years.	s. ☐	☐	Medical rejection by military service
c. ☐	☐	Unconsciousness for any reason	i. ☐	☐	Stomach, liver, or intestinal trouble				t. ☐	☐	Rejection for life or health insurance
d. ☐	☐	Eye or vision trouble except glasses	j. ☐	☐	Kidney stone or blood in urine	o. ☐	☐	Alcohol dependence or abuse	u. ☐	☐	Admission to hospital
e. ☐	☐	Hay fever or allergy	k. ☐	☐	Diabetes	p. ☐	☐	Suicide attempt	x. ☐	☐	Other illness, disability, or surgery
f. ☐	☐	Asthma or lung disease	l. ☐	☐	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	q. ☐	☐	Motion sickness requiring medication			

Conviction and/or Administrative Action History — See Instructions Page

Yes	No		Yes	No	
v. ☐	☐	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.	w. ☐	☐	History of nontraffic conviction(s) (misdemeanors or felonies).

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)** **Yes** **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		

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 Pass 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/	Pass
Left	20/	Corrected to 20/	Left	20/	Corrected to 20/	Left	20/	Corrected to 20/	Fail
Both	20/	Corrected to 20/	Both	20/	Corrected to 20/	Both	20/	Corrected to 20/	

53. **Field of Vision** Normal Abnormal	54. **Heterophoria 20'** (in prism diopters)	**Esophoria**	**Expophoria**	**Right Hyperphoria**	**Left Hyperphoria**

55. **Blood Pressure** (Sitting, mm of Mercury) Systolic / Diastolic	56. **Pulse** (Resting)	57. **Urinalysis** (if abnormal, give results) Normal 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 YES NO **Abnormal Physical Findings** YES NO

61. **Applicant's Name**

62. **Has Been Issued --** Medical Certificate Medical & Student Pilot Certificate
No Certificate Issued -- Deferred for Further Evaluation
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	
		AME Serial Number
	City State Zip Code	AME Telephone ( )