LOGO

CIVIL AVIATION ADMINISTRATION / MEMBER STATE

APPLICATION FORM FOR AN AVIATION MEDICAL CERTIFICATE

Complete this page fully and in block capitals - Refer to instructions pages for details.

MEDICAL IN CONFIDENCE

(1) State of licence issue: **Florida**	(2) Medical certificate applied for: class 1 ☐ class 2 ☒ LAPL ☐ Others ☐	
(3) Surname: **Lawrence**	(4) Previous surname(s):	(12) Application Initial ☒ Revalidation/Renewal ☐
(5) Forenames: **Jenn**	(6) Date of birth(dd/mm/yyyy): **March 10th 1997** (7) Sex Male Female ☒	(13) Reference number: **L14754896**
(8) Place and country of birth: **New-York**	(9) Nationality: **French**	(14) Type of licence applied for: **IFR**
(10) Permanent address: **741 SE Franklin road street Miami, FL 18400** Country : Telephone No. : Mobile No. : e-mail :	(11) Postal address (if different) **741 SE Franklin road street Miami, FL 18400** Country : **USA** Telephone No. :	(15) Occupation (principal) **CEO** (16) Employer (17) Last medical examination Date: **10/11/2021** Place: **San Francisco**

(18) Aviation licence(s) held (type): Licence number: **L28W771488** State of issue: **Florida**	(19) Any Limitations on Licence/ Medical Certificate No ☒ Yes ☐ Details:
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing authority? No ☒ Yes ☐ Date: Country: Details:	(21) Flight time hours total: **2010** (22)Flight time hours since last medical: **254**
	(23) Aircraft class /type(s) presently flown: **Type 1**
(24) Any aviation accident or reported incident since last medical examination? No ☒ Yes ☐ Date: Place: Details:	(25) Type of flying intended:
	(26) Present flying activity: Single pilot ☐ Multi pilot ☐
(27) Do you drink alcohol? ☒ No ☐ Yes, amount	(28) Do you currently use any medication? No ☐ Yes ☐ State drug, dose, date started and why:
(29) Do you smoke tobacco? ☐ No, never ☐ No, date stopped: ☐ Yes, state type and amount:	

General and medical history: Do you have, or have you ever had, any of the following? (Please tick).

Note: if revalidating at the same venue as last examination, tick only boxes relating to any medical/surgical/ophthalmic or other events or changes since last examined. If 'no change, state this in 'Remarks,.

	Yes	No		Yes	No		Yes	No	**Family history of:**	Yes	No
101 Eye trouble/eye operation			112 Nose, throat or speech disorder			123 Malaria or other tropical disease			170 Heart disease		
102 Spectacles and/or contact lenses ever worn			113 Head injury or concussion			124 A positive HIV test			171 High blood pressure		
			114 Frequent or severe headaches			125 Sexually transmitted disease			172 High cholesterol leve		
103 Spectacle/contact lens prescrip-			115 Dizziness or fainting spells			126 Admission to hospital			173 Epilepsy		
tions change since last medical exam.			116 Unconsciousness for any reason			127 Any other illness or injury			174 Mental illness		
104 Hay fever, other allergy			117 Neurological disorders; stroke,			128 Visit to medical practitioner			175 Diabetes		
105 Asthma, lung disease			epilepsy, seizure, paralysis, etc			since last medical examination			176 Tuberculosis		
106 Heart or vascular trouble			118 Psychological/psychiatric trouble			129 Refusal of life insurance			177 Allergy/asthma/eczema		
107 High or low blood pressure			of any sort			130 Refusal of flying licence			178 Inherited disorders		
108 Kidney stone or blood in urine			119 Alcohol/drug/substance abuse						179 Glaucoma		
109 Diabetes, hormone disorder			120 Attempted suicide								
110 Stomach, liver or intestinal			121 Motion sickness requiring			132 Medical rejection from or for			**Females only:**		
trouble			medication			military service			150 Gynaecological,		
111 Deafness, ear disorder			122 Anaemia / Sickle cell trait/other			133 Award of pension or			menstrual problems		
			blood disorders			compensation for injury or illness			151 Are you pregnant?		

(30) **Remarks:** If previously reported and no change since, so state.

(31) **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.

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 Medical Assessor of the Licensing Authority and where necessary to the Medical Asessor of another EASA Member State, 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/GMP (witness)
---	---	---