MEDICAL IN CONFIDENCE

FORM FOR THE TRANSFER OF MEDICAL RECORDS BETWEEN MEDICAL SECTIONS OF LICENCING AUTHORITIES

The form should be completed in block capitals using black or blue ink.

CONSENT BY APPLICANT
I, (Name of applicant).....consent to my aeromedical records being transferred between the Authority Medical Sections of the Licensing Authorities stated below and accept responsibility for any fees incurred in translating or transferring my records. Signature..... Date.....

Please note:
Only English Language accepted: (Any charges incurred for translations are the responsibility of the Applicant)

ITEM	DESCRIPTION		
1	State of Transfer TO: Address: Telephone: Email:		
2	State of Transfer FROM: Address: Telephone: Email:	The Civil Aviation Authority POLAND Aeromedical Section (AMS) Marcina Flisa Str. 2 02-247 WARSAW (48) 22 520 74 27 nll@ulc.gov.pl	
3	Full name of holder		
4	Address of holder		
5	Date of birth (dd/mm/yyyy)		
6	Nationality of holder		
7	Reference Number		
8	Licence(s) Held (e.g. ATPL/CPL/PPL)		Restrictions or Limitations (if any)

ITEM	MEDICAL HISTORY TO BE COMPLETED BY MEDICAL ASSESSOR OF TRANSFERRING AUTHORITY
9	Any previous State(s) of Licence Issue prior to current State (or where medical records have been held) No □ Yes □ ……enclose details Period of Medical Records Held (Dates From/To): …… **If there is insufficient space on this form for any information, please use additional pages.** Copies of the applicant's Aeromedical records should be enclosed with this form. The minimum documents required for transfer: □ **Copy of initial medical application and examination report forms** □ **All SOLI forms (and supporting documents) from previous transfers.** □ **Summary of medical history (see below) with supporting aeromedical assessments & clinical reports** □ **Copy of current medical application and examination report forms** □ **Copy of latest electrocardiogram and audiogram** □ **Copy of current medical certificate** **Summary of medical history** (with dates) to include relevant inactive conditions and active conditions requiring follow-up

VERIFICATION		
I (name)....., Medical Assessor of..... ..... Authority certify that the details given above and on any additional pages included are true and correct. Further information/records are available on request		
Signature	Date: (dd/mm/yyyy)	Medical Assessor stamp