MBF-ATC Health Declaration Form

Eye or vision trouble?	Υ	N	Diagnosed depression?	Υ	١
Eye or corneal surgery?	Υ	N	Anxiety disorder/panic disorder?	Υ	Ν
Hay fever?	Υ	Ν	Learning difficulty?	Υ	N
Middle ear infection?	Υ	N	Attention deficit or hyperactivity disorder?	Υ	N
Sinusitis?	Υ	N	Post traumatic stress disorder?	Υ	N
Hearing trouble?	Υ	N	Suicide attempt?	Υ	Ν
Any other ears, nose & throat problems or surgery or dental issues?	Υ	N	Any other mental illness or symptoms (including stress, depression or anxiety)?	Υ	١
Problems with balance?	Υ	N	Use of legal or illegal recreational drugs or substances?	Υ	١
Asthma or wheezing?	Υ	N	Substance dependence or substance abuse?	Υ	١
Chronic cough?	Υ	N	Muscle, bone or joint injury?	Υ	N
Any other lung problem?	Υ	N	Back pain, injury or "back trouble"?	Υ	N
Any shortness of breath?	Υ	N	Swollen or painful joints?	Υ	T_
Coughed or vomited blood?	Υ	N	Suffered any pain severe enough to be disabling?	Υ	T
Pulmonary embolism or deep vein thrombosis?	Υ	N	Passed blood with or in urine or faeces?	Υ	T
Any allergy?	Υ	N	Kidney, bladder or prostatic disease?	Υ	١
Heart problem?	Υ	N	Easy fatigue-ability or sleep in the day?	Y	١
Vascular problem?	Y	N	Investigations for abnormal glucose tolerance, hig blood sugar, or diabetes?	h Y	١
Suffered any chest pain?	Y	N	Medical certificate for absence of 7 or more days from work?	Υ	١
Rheumatic fever?	Υ	N	Rejection or premium loading for life, health or los of licence insurance?	S Y	١
High or low blood pressure?	Υ	N	Rejection or retirement from employment on medical grounds?	Υ	١
Severe abdominal pain?	Y	N	Admission to hospital, psychiatric or in-patient facility?	Υ	١
Hernia?	Y	N	Taken any type of medicine or medication or alternative medicine for more than 2 weeks?	Υ	١
Oesophagus, stomach, liver, gall bladder or intestinal trouble?	Υ	N	Had a positive laboratory test for HIV infection, or have you suffered from AIDS?	Υ	١
Anaemia or blood disease?	Υ	Ν	Sexually transmitted disease?	Υ	١
Diagnosed or treated for cancer, tumour, growth or malignancy (including skin cancer)?	Υ	N	Investigation for any disorder?	Y	١
Headaches/migraines which have interfered in any way with daily living?	Y	N	Any major medical or surgical procedure?	Υ	١
Headaches/migraines requiring medication?	Y	N	Day surgery?	Υ	N
Dizziness or fainting spells?	Y	N	Any other illness, disability, debility, infirmity, treatment or surgery or investigations?	Υ	١
Unconsciousness for any reason?	Υ	N			Ī
Head injury?	Υ	N	Females only:		
Seizures/fits/faint/collapse?	Υ	N	Any troubling menstrual problems?	Υ	١
Stroke?	Υ	N	Other gynaecological problem?	Υ	١
Paralysis?	Υ	N	Any obstetric problem?	Υ	١
Any other neurological disorder?	Υ	N	Breast lump or other breast problem?	Υ	N

are you currently experiencing arry or the folio	7 4 4 11 1 6	,.
Diagnosed depression?	Υ	N
Anxiety disorder/panic disorder?	Υ	N
Learning difficulty?	Υ	Ν
Attention deficit or hyperactivity disorder?	Υ	Ν
Post traumatic stress disorder?	Υ	Ν
Suicide attempt?	Υ	Ν
Any other mental illness or symptoms (including stress, depression or anxiety)?	Υ	N
Use of legal or illegal recreational drugs or substances?	Υ	N
Substance dependence or substance abuse?	Υ	Ν
Muscle, bone or joint injury?	Υ	Ν
Back pain, injury or "back trouble"?	Υ	Ν
Swollen or painful joints?	Υ	N
Suffered any pain severe enough to be disabling?	Υ	Ν
Passed blood with or in urine or faeces?	Υ	N
Kidney, bladder or prostatic disease?	Υ	N
Easy fatigue-ability or sleep in the day?	Υ	N
Investigations for abnormal glucose tolerance, high blood sugar, or diabetes?	Υ	N
Medical certificate for absence of 7 or more days from work?	Υ	Ν
Rejection or premium loading for life, health or loss of licence insurance?	Υ	N
Rejection or retirement from employment on medical grounds?	Υ	N
Admission to hospital, psychiatric or in-patient facility?	Υ	Ν
Taken any type of medicine or medication or alternative medicine for more than 2 weeks?	Υ	N
Had a positive laboratory test for HIV infection, or have you suffered from AIDS?	Υ	N
Sexually transmitted disease?	Υ	Ν
Investigation for any disorder?	Υ	N
Any major medical or surgical procedure?	Υ	N
Day surgery?	Υ	N
Any other illness, disability, debility, infirmity, treatment or surgery or investigations?	Υ	N
Females only:		
Any troubling menstrual problems?	Υ	N
Other gynaecological problem?	Υ	N
Any obstetric problem?	Υ	N
Breast lump or other breast problem?	Υ	Ν

If you answered "Yes" to any of the above questions, please provide all details of each instance - use extra pages or attach any documents as required

Please turn over for further questions

Has any medical certificate ever been denied, suspended or revoked within or outside of New Zealand?	Υ	N
Has any assessment been deferred?	Υ	Ν
Do you drink alcohol: If yes, how much do you drink per week (be specific)? Has a health professional ever expressed concern over your consumption of alcohol or have you	Υ	N
ever been identified by a health professional as having a drinking problem, which might include the use of terms such as alcohol abuse, misuse or alcohol dependence?	Υ	N
Have you ever received a conviction or formal caution for any alcohol or drug related behaviour including drink driving, public intoxication, or disorderly conduct?	Υ	Ν
Has your alcohol consumption, or behaviour while under the influence of alcohol, ever led to a formal warning or other disciplinary procedure by your current or any past employer?	Υ	N
Is any action against you pending, whether by the police or your employer, in respect of any alcohol or drug-related issue?	Υ	Ν
Have you visited a health professional within the last three years (other than for a routine CAA medical or consultation with your certifying ME)?	Υ	N
Are you aware of any symptoms signs or concerns regarding your health which should reasonably be investigated or reported to a health professional?	Υ	N
Have you received any Notice under Section 27 I of the Civil Aviation Act (suspension, restriction, endorsements, etc)?	Υ	N
Have you at any time been in receipt of a benefit from a loss of licence policy or other disability policy? If so, please supply details.	Υ	N
Is there any other history of illness or health concern which might influence the acceptance of this application? If so, please supply details.	Υ	N
Has a health professional ever expressed concern at your use of prescription or over the counter	Y	N
medications such as, but not limited to, those for pain relief, stress or sleep problems? Have you ever been diagnosed with a sleep disorder such as obstructive sleep apnoea syndrome?	Υ	N
Are you aware of any symptoms, signs or concerns regarding your health which should be	Y	N
investigated or reported to a health professional?		IN
<u>Family history</u> : Have any members of your family had vascular disease, hypertension, diabetes, heart disease, psychiatric disease or neurological or other diseases (please mention age when condition discovered)? Mother Father Sblings Grandparents	Y	N

If you answered "Yes" to any of the above questions, please provide all details of each instance - use extra pages or attach any documents as required.

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I hereby declare and warrant

- 1. That the answers given above are in every respect true, and correct and complete.
- 2. That I have not sustained any bodily injury or suffered from any illness which may result in the permanent or temporary loss or cancellation of my licence, medical validity certificate or other document that I am required to hold to enable me to exercise the privileges of my New Zealand Civil Aviation Certificate.
- 3. That I am not at the present time afflicted by any sickness, disease, deafness or deterioration in health and that I have not withheld any information regarding my health and medical history.

Any Medical Adviser to the New Zealand Air Line Pilots' Mutual Benefit Fund - Air Traffic Controllers is authorised to see this application and to obtain such information as he/she shall require from the Principal Medical Officer of any Civil Aviation Licencing Authority or any medical practitioner I have consulted regarding my health.

I acknowledge and authorise that the information given in my application for membership or obtained pursuant to the above authority can be disclosed to such parties as the Trustees of the Fund or their medical adviser considers necessary to assess my entitlement to any benefit or right to continued membership of the Fund.

Any information obtained pursuant to this authority will be held at the office of the Mutual Benefit Fund and I understand that I have the right of access to and correction of any information held about me.