Consent For CAA Aero Medical Examiner (AME) And Practice Staff To Access CAA Medical Records

Applicant Name: _____

Date Of Birth: _____ CAA Licence/Reference No: _____

Address: _____

_____

_____

AME Name: _____

AME Number: _____

Address: _____

_____

I give my consent for the AME above and his/her staff to access my relevant CAA medical records for the purposes of providing aeromedical advice, medical examinations or medical assessments.

Signature_____

Date _____

Please scan this form when signed with the photographic ID page of a passport, or UK driving licence in the area below and send via post our email to your AME.