# ANNEX IV (PART-MED)

## SUBPART A – GENERAL REQUIREMENTS

### SECTION 1 – GENERAL

## MED.A.001 Competent authority

*Regulation (EU) 2019/27*

For the purpose of this Annex (Part-MED), the competent authority shall be:

(a) for aero-medical centres (AeMCs):

(1) the authority designated by the Member State, where the AeMC has its principal place of business;

(2) the Agency, if the AeMC is located in a third country;

(b) for aero-medical examiners (AMEs):

(1) the authority designated by the Member State where the AME has its principal place of practice;

(2) if the principal place of practice of an AME is located in a third country, the authority designated by the Member State to which the AME applies for the issue of the AME certificate;

(c) for general medical practitioners (GMPs), the authority designated by the Member State to which the GMP notify their activity;

(d) for occupational health medical practitioners (OHMPs) assessing the medical fitness of cabin crew, the authority designated by the Member State to which the OHMP notify their activity.

## MED.A.005 Scope

*Regulation (EU) 2019/27*

This Annex (Part-MED) establishes the requirements for:

(a) the issuance, validity, revalidation and renewal of the medical certificate required for exercising the privileges of a pilot licence or of a student pilot;

(b) the medical fitness of cabin crew;

(c) the certification of AMEs;

(d) the qualification of GMPs and OHMPs.

# MED.A.010 Definitions

*Regulation (EU) 2024/2076*

For the purpose of this Annex (Part-MED), the following definitions shall apply:

— 'limitation' means a condition placed on the medical certificate or cabin crew medical report that shall be complied with whilst exercising the privileges of the licence or cabin crew attestation;

— 'aero-medical examination' means an inspection, palpation, percussion, auscultation or any other means of investigation for determining the medical fitness to exercise the privileges of the licence, or to carry out cabin crew safety duties;

— 'aero-medical assessment' means the conclusion on the medical fitness of an applicant based on the evaluation of the applicant as required in this Annex (Part-MED) and further examinations and medical tests as clinically indicated;

— 'significant' means a degree of a medical condition, the effect of which would prevent the safe exercise of the privileges of the licence or of the cabin crew safety duties;

— 'applicant' means a person applying for, or being the holder of, a medical certificate who undergoes an aero-medical assessment of fitness to exercise the privileges of the licence, or to carry out cabin crew safety duties;

— 'medical history' means a narrative or record of past diseases, injuries, treatments or other medical facts, including unfit assessment(s) or limitation of a medical certificate, that are or may be relevant to an applicant's current state of health and aero-medical fitness;

— 'licensing authority' means the competent authority of the Member State that issued the licence, or to which a person applies for the issuance of a licence, or, when a person has not yet applied for a licence, the competent authority as determined in accordance with FCL.001 of Annex I (Part-FCL);

— 'colour safe' means the ability of an applicant to readily distinguish the colours used in air navigation and to correctly identify aviation coloured lights;

— 'helicopter emergency medical services (HEMS) operation' means a "HEMS flight" as defined in point 61 of Annex I to Regulation (EU) No 965/2012;

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

— 'investigation' means the assessment of a suspected pathological condition of an applicant by means of examinations and tests in order to verify the presence or absence of a medical condition;

— 'accredited medical conclusion' means the conclusion reached by one or more medical experts acceptable to the licensing authority, on the basis of objective and non-discriminatory criteria, for the purposes of the case concerned, in consultation with flight operations or other experts as necessary, for which an operational risk assessment may be appropriate;

— 'misuse of substances' means the use of one or more psychoactive substances by aircrew in a way that, alternatively or jointly:

(a) constitutes a direct hazard to the user or endangers the lives, health or welfare of others;

(b) causes or worsens an occupational, social, mental or physical problem or disorder;

— ‘psychoactive substances’ means alcohol, opioids, cannabinoids, sedatives and hypnotics, cocaine, other psychostimulants, hallucinogens, and volatile solvents, with the exception of caffeine and tobacco;;

— ‘refractive error’ means the deviation from emmetropia measured in dioptres in the most ametropic meridian, measured by standard methods.

## MED.A.015 Medical confidentiality

*Regulation (EU) 2019/27*

All persons involved in aero-medical examinations, assessments and certification shall ensure that medical confidentiality is respected at all times.

## AMC1 MED.A.015 Medical confidentiality

*ED Decision 2019/002/R*

To ensure medical confidentiality, all medical reports and records should be securely held with accessibility restricted to personnel authorised by the medical assessor or, where applicable, by the head of the aero-medical centre (AEMC), the aero-medical examiner (AME), general medical practitioner (GMP) or occupational health medical practitioner (OHMP).

## MED.A.020 Decrease in medical fitness

*Regulation (EU) 2019/27*

(a) Licence holders shall not exercise the privileges of their licence and related ratings or certificates, and student pilots shall not fly solo, at any time when they:

(1) are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges;

(2) take or use any prescribed or non-prescribed medication which is likely to interfere with the safe exercise of the privileges of the applicable licence;

(3) receive any medical, surgical or other treatment that is likely to interfere with the safe exercise of the privileges of the applicable licence.

(b) In addition, holders of a medical certificate shall, without undue delay and before exercising the privileges of their licence, seek aero-medical advice from the AeMC, AME or GMP, as applicable, when they:

(1) have undergone a surgical operation or invasive procedure;

(2) have commenced the regular use of any medication;

(3) have suffered any significant personal injury involving incapacity to function as a member of the flight crew;

(4) have been suffering from any significant illness involving incapacity to function as a member of the flight crew;

(5) are pregnant;

(6) have been admitted to hospital or medical clinic;

(7) first require correcting lenses.

(c) In the cases referred to in point (b):

(1) holders of class 1 and class 2 medical certificates shall seek the aero-medical advice of an AeMC or AME. In that case, the AeMC or AME shall assess their medical fitness and decide whether they are fit to resume the exercise of their privileges;

(2) holders of light aircraft pilot licence medical certificates shall seek the aero-medical advice of an AeMC, an AME or the GMP who signed the medical certificate. In that case, the AeMC, AME or GMP shall assess their medical fitness and decide whether they are fit to resume the exercise of their privileges.

(d) Cabin crew members shall not perform duties on an aircraft and, where applicable, shall not exercise the privileges of their cabin crew attestation when they are aware of any decrease in their medical fitness, to the extent that this medical condition might render them unable to discharge their safety duties and responsibilities.

(e) In addition, if any of the medical conditions specified in points (1) to (5) of point (b) apply, cabin crew members shall, without undue delay, seek the advice of an AME, AeMC or OHMP, as applicable. In that case, the AME, AeMC or OHMP shall assess the medical fitness of the cabin crew members and decide whether they are fit to resume their safety duties.

## GM1 MED.A.020 Decrease in medical fitness

*ED Decision 2019/002/R*

**MEDICATION – GUIDANCE FOR PILOTS AND CABIN CREW MEMBERS**

(a) Any medication can cause side effects, some of which may impair the safe performance of flying duties. Equally, symptoms of colds, sore throats, diarrhoea and other abdominal upsets may cause little or no problem whilst on the ground but may distract the pilot or cabin crew member and degrade their performance whilst on duty. The in-flight environment may also increase the severity of symptoms which may only be minor whilst on the ground. Therefore, one issue with medication and flying is the underlying condition and, in addition, the symptoms may be compounded by the side effects of the medication prescribed or bought over the counter for treatment. This guidance material provides some help to pilots and cabin crew in deciding whether expert aero-medical advice by an AME, AeMC, GMP, OHMP or medical assessor is needed.

(b) Before taking any medication and acting as a pilot or cabin crew member, the following three basic questions should be satisfactorily answered:

(1) Do I feel fit to fly?

(2) Do I really need to take medication at all?

(3) Have I given this particular medication a personal trial on the ground to ensure that it will not have any adverse effects on my ability to fly?

(c) Confirming the absence of adverse effects may well need expert aero-medical advice.

(d) The following are some widely used medicines with a description of their compatibility with flying duties:

(1) Antibiotics. Antibiotics may have short-term or delayed side effects which can affect pilot or cabin crew performance. More significantly, however, their use usually indicates that an infection is present and, thus, the effects of this infection may mean that a pilot or cabin crew member is not fit to fly and should obtain expert aero-medical advice.

(2) Anti-malaria drugs. The decision on the need for anti-malaria drugs depends on the geographical areas to be visited, and the risk that the pilot or cabin crew member has of being exposed to mosquitoes and of developing malaria. An expert medical opinion should be obtained to establish whether anti-malaria drugs are needed and what kind of drugs should be used. Most of the anti-malaria drugs (atovaquone plus proguanil, chloroquine, doxycycline) are compatible with flying duties. However, adverse effects associated with mefloquine include insomnia, strange dreams, mood changes, nausea, diarrhoea and headaches. In addition, mefloquine may cause spatial disorientation and lack of fine coordination and is, therefore, not compatible with flying duties.

(3) Antihistamines. Antihistamines can cause drowsiness. They are widely used in 'cold cures' and in treatment of hay fever, asthma and allergic rashes. They may be in tablet form or a constituent of nose drops or sprays. In many cases, the condition itself may preclude flying, so that, if treatment is necessary, expert aero-medical advice should be sought so that so-called non-sedative antihistamines, which do not degrade human performance, can be prescribed.

(4) Cough medicines. Antitussives often contain codeine, dextromethorfan or pseudo-ephedrine which are not compatible with flying duties. However, mucolytic agents (e.g. carbocysteine) are well-tolerated and are compatible with flying duties.

(5) Decongestants. Nasal decongestants with no effect on alertness may be compatible with flying duties. However, as the underlying condition requiring the use of decongestants may be incompatible with flying duties, expert aero-medical advice should be sought. For example, oedema of the mucosal membranes causes difficulties in equalising the pressure in the ears or sinuses.

(6) Nasal corticosteroids are commonly used to treat hay fever, and they are compatible with flying duties.

(7) (i) Common pain killers and antifebrile drugs. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and paracetamol, commonly used to treat pain, fever or headaches, may be compatible with flying duties. However, the pilot or cabin crew member should give affirmative answers to the three basic questions listed in (b) before using the medication and carrying out flying duties.

(ii) Strong analgesics. The more potent analgesics including codeine are opiate derivatives, and may produce a significant decrement in human performance and, therefore, are not compatible with flying duties.

(8) Anti-ulcer medicines. Gastric secretion inhibitors such as H2 antagonists (e.g. ranitidine, cimetidine) or proton pump inhibitors (e.g. omeprazole) may be acceptable after diagnosis of the pathological condition. It is important to seek for the medical diagnosis and not to only treat the dyspeptic symptoms.

(9) Anti-diarrhoeal drugs. Loperamide is one of the more common anti-diarrhoeal drugs and is usually safe to take whilst flying. However, the diarrhoea itself often makes the pilot and cabin crew member unfit for flying duties.

(10) Hormonal contraceptives and hormone replacement therapy usually have no adverse effects and are compatible with flying duties.

(11) Erectile dysfunction medication. This medication may cause disturbances in colour vision and dizziness. There should be at least 6 hours between taking sildenafil and flying duty; and 36 hours between taking vardenafil or tadalafil and flying duty.

(12) Smoking cessation. Nicotine replacement therapy may be acceptable. However, other medication affecting the central nervous system (buproprion, varenicline) is not acceptable for pilots.

(13) High blood pressure medication. Most anti-hypertensive drugs are compatible with flying duties However, if the level of blood pressure is such that drug therapy is required, the pilot or cabin crew member should be monitored for any side effects before carrying out flying duties. Therefore, consultation with the AME, AeMC, GMP, OHMP or medical assessor as applicable, is needed.

(14) Asthma medication. Asthma has to be clinically stable before a pilot or cabin crew member can return to flying duties. The use of respiratory aerosols or powders, such as corticosteroids, beta-2-agonists or chromoglycic acid may be compatible with flying duties. However, the use of oral steroids or theophylline derivatives is incompatible with flying duty. Pilots or cabin crew members using medication for asthma should consult the AME, AeMC, GMP, OHMP or medical assessor, as applicable.

(15) Tranquillisers and sedatives. The inability to react, due to the use of this group of medicines, has been a contributory cause to fatal aircraft accidents. In addition, the underlying condition for which these medications have been prescribed will almost certainly mean that the mental state of a pilot or cabin crew member is not compatible with flying duties.

(16) Sleeping tablets. Sleeping tablets dull the senses, may cause confusion and slow reaction times. The duration of effect may vary from individual to individual and may be unduly prolonged. Expert aero-medical advice should be obtained before using sleeping tablets.

(17) Melatonin. Melatonin is a hormone that is involved with the regulation of the circadian rhythm. In some countries it is a prescription medicine, whereas in most other countries it is regarded as a ‘dietary supplement’ and can be bought without any prescription. The results from the efficiency of melatonin in treatment of jet lag or sleep disorders have been contradictory. Expert aero-medical advice should be obtained.

(18) Coffee and other caffeinated drinks may be acceptable, but excessive coffee drinking may have harmful effects, including disturbance of the heart’s rhythm. Other stimulants including caffeine pills, amphetamines, etc. (often known as ‘pep’ pills) used to maintain wakefulness or suppress appetite can be habit forming. Susceptibility to different stimulants varies from one individual to another, and all may cause dangerous overconfidence. Overdosage causes headaches, dizziness and mental disturbance. These other stimulants should not be used.

(19) Anaesthetics. Following local, general, dental and other anaesthetics, a period of time should elapse before returning to flying. The period will vary considerably from individual to individual, but a pilot or cabin crew member should not fly for at least 12 hours after a local anaesthetic, and for at least 48 hours after a general, spinal or epidural anaesthetic (see MED.A.020).

(e) Many preparations on the market nowadays contain a combination of medicines. It is, therefore, essential that if there is any new medication or dosage, however slight, the effect should be observed by the pilot or the cabin crew member on the ground prior to flying. It should be noted that medication which would not normally affect pilot or cabin crew performance may do so in individuals who are ‘oversensitive’ to a particular preparation. Individuals are, therefore, advised not to take any medicines before or during flight unless they are completely familiar with their effects on their own bodies. In cases of doubt, pilots and cabin crew members should consult an AME, AeMC, GMP, OHMP or medical assessor, as applicable.

(f) Other treatments

Alternative or complementary medicine, such as acupuncture, homeopathy, hypnotherapy and several other disciplines, is developing and gaining greater credibility. Such treatments are more acceptable in some States than others. There is a need to ensure that 'other treatments', as well as the underlying condition, are declared and considered by the AME, AeMC, GMP, OHMP or medical assessor, as applicable, for assessing fitness.

## MED.A.025 Obligations of the AeMC, AME, GMP and OHMP

*Regulation (EU) 2019/27*

(a) When conducting aero-medical examinations and aero-medical assessments as required in this Annex (Part-MED), the AeMC, AME, GMP and OHMP shall:

(1) ensure that communication with the applicant can be established without language barriers;

(2) make the applicant aware of the consequences of providing incomplete, inaccurate or false statements on their medical history;

(3) notify the licensing authority, or, in the case of cabin crew attestation holders, notify the competent authority, if the applicant provides incomplete, inaccurate or false statements on their medical history;

(4) notify the licensing authority if an applicant withdraws the application for a medical certificate at any stage of the process.

(b) After completion of the aero-medical examinations and assessments, the AeMC, AME, GMP and OHMP shall:

(1) inform the applicant whether he or she is fit, unfit or referred to the medical assessor of the licensing authority, AeMC or AME, as applicable;

(2) inform the applicant of any limitation that may restrict flight training or the privileges of his or her licence or cabin crew attestation, as applicable;

(3) if the applicant has been assessed as unfit, inform him or her of his or her right to have the decision reviewed in accordance with the procedures of the competent authority;

(4) in the case of applicants for a medical certificate, submit without delay to the medical assessor of the licensing authority a signed, or electronically authenticated, report containing the detailed results of the aero-medical examinations and assessments as required for the class of medical certificate–and a copy of the application form, the examination form, and the medical certificate;

(5) inform the applicant of his or her responsibilities in the case of decrease in medical fitness, as specified in point MED.A.020.

(c) Where consultation with the medical assessor of the licensing authority is required in accordance with this Annex (Part-MED), the AeMC and AME shall follow the procedure established by the competent authority.

(d) AeMCs, AMEs, GMPs and OHMPs shall maintain records with details of aero-medical examinations and assessments performed in accordance with this Annex (Part-MED) and their results for a minimum of 10 years, or for a longer period if so determined by national legislation.

(e) AeMCs, AMEs, GMPs and OHMPs shall submit to the medical assessor of the competent authority, upon request, all aero-medical records and reports, and any other relevant information, when required for:

(1) medical certification;

(2) oversight functions.

(f) AeMCs and AMEs shall enter or update the data included in the European Aero-Medical Repository in accordance with point (c) of point ARA.MED.160.

## AMC1 MED.A.025 Obligations of the AeMC, AME, GMP and OHMP

*ED Decision 2019/002/R*

(a) If the medical examination is carried out by two or more AMEs or GMPs, only one of them should be responsible for coordinating the results of the examination, evaluating the findings with regard to medical fitness, and signing the report.

(b) The applicant should be made aware that the associated medical certificate or cabin crew report may be suspended or revoked if the applicant provides incomplete, inaccurate or false statements on their medical history to the AeMC, AME, GMP or OHMP.

(c) In cases where the AeMC or AME is required to assess the fitness of an applicant for a class 2 medical certificate in consultation with the medical assessor of the licensing authority, they should document the consultation in accordance with the procedure established by the competent authority.

(d) The AeMC, AME, GMP or OHMP should give advice to the applicant on treatment and preventive measures if, during the course of the examination, medical conditions or risk factors are identified which may endanger the medical fitness of the applicant in the future.

(e) When data is not being properly recorded in the European aero-medical data repository (EAMR due to unserviceability of the system, the AeMCs and AMEs should enter, or correct the existing data, in the EAMR without undue delay when the system recovers.

(f) In case of denial or referral to the licensing authority, the AeMC, AME, GMP or OHMP should inform the applicant in writing regarding the result of the assessment in a form and manner established by the competent authority.

## GM1 MED.A.025 Obligations of the AeMC, AME, GMP and OHMP

*ED Decision 2019/002/R*

**GUIDELINES FOR THE AeMC, AME OR GMP CONDUCTING THE MEDICAL EXAMINATIONS AND ASSESSMENTS FOR MEDICAL CERTIFICATION OF PILOTS**

(a) Before performing the medical examination, the AeMC, AME or GMP should:

(1) verify the applicant's identity by checking their identity card, passport, driving licence or other official document containing a photograph of the applicant;

(2) obtain details of the applicant's flight crew licence from the applicant's licensing authority if they do not have their licence with them;

(3) except for initial applicants, obtain details of the applicant's most recent medical certificate from the medical assessor of the applicant's licensing authority if they do not have their certificate with them;

(4) in the case of a specific medical examination(s) (SIC) limitation on the existing medical certificate, obtain details of the specific medical condition and any associated instructions from the medical assessor of the applicant's licensing authority. This could include, for example, a requirement to undergo a specific examination or test;

(5) except for initial applicants, ascertain, from the previous medical certificate, which routine medical test(s) should be conducted, for example electrocardiography (ECG);

(6) provide the applicant with the application form for a medical certificate and the instructions for completion and ask the applicant to complete the form but not to sign it yet;

(7) go through the form with the applicant and give information to help the applicant understand the significance of the entries and ask any questions which might help the applicant to recall important historical medical data;

(8) verify that the form is complete and legible, ask the applicant to sign and date the form and then sign it as well. If the applicant declines to complete the application form fully, inform the applicant that it may not be possible to issue a medical certificate regardless of the outcome of the clinical examination and assessment.

(b) Once all the items in (a) have been addressed, the AeMC, AME or GMP should:

(1) perform the medical examination of the applicant in accordance with the applicable rules;

(2) arrange for additional specialist medical examinations, such as otorhinolaryngology (ENT) or ophthalmology, to be conducted as applicable and obtain the associated report forms or reports;

(3) complete the medical examination report form in accordance with the associated instructions for completion;

(4) ensure that all of the report forms are complete, accurate and legible.

(c) Once all the actions in (b) have been carried out, the AeMC, AME or GMP should review the report forms and:

(1) if satisfied that the applicant meets the applicable medical requirements as set out in Part-MED, issue a medical certificate for the appropriate class, with limitations if necessary. The applicant should sign the certificate once signed by the AeMC, AME or GMP; or

(2) if the applicant does not meet the applicable medical requirements, or if the fitness of the applicant for the class of medical certificate applied for is in doubt:

(i) refer the decision on medical fitness to, or consult the decision on medical fitness with, the medical assessor of the licensing authority or AME in compliance with MED.B.001; or

(ii) deny issuance of a medical certificate, explain the reason(s) for denial to the applicant and inform them of their right of a review according to the procedures of the competent authority.

(d) The AeMC, AME or GMP should send the documents as required by MED.A.025(b) to the medical assessor of the applicant's licensing authority within 5 days from the date of the medical examination. If a medical certificate has been denied or the decision has been referred, the documents should be sent to the medical assessor of the licensing authority on the same day that the denial or referral decision is reached.

# SECTION 2 - REQUIREMENTS FOR MEDICAL CERTIFICATES

## MED.A.030 Medical certificates

*Regulation (EU) 2020/359*

(a) A student pilot shall not fly solo unless that student pilot holds a medical certificate, as required for the relevant licence.

(b) An applicant for a licence, in accordance with Annex I (Part-FCL), shall hold a medical certificate issued in accordance with this Annex (Part-MED) and appropriate to the licence privileges applied for.

(c) When exercising the privileges of a:

(1) light aircraft pilot licence (LAPL), a balloon pilot licence (BPL) issued in accordance with Annex III (Part-BFCL) to Commission Regulation (EU 2018/395, or a sailplane pilot licence (SPL) issued in accordance with Annex III (Part-SFCL) to Commission Implementing Regulation (EU) 2018/1976, the pilot shall hold at least a valid LAPL medical certificate;

(2) private pilot licence (PPL), the pilot shall hold at least a valid class 2 medical certificate;

(3) BPL for the purpose of:

(i) commercial passenger ballooning, the pilot shall hold at least a valid class 2 medical certificate;

(ii) commercial operation other than commercial passenger ballooning, with more than 4 persons on board the aircraft, the pilot shall hold at least a valid class 2 medical certificate;

(4) SPL for the purpose of commercial sailplane operations other than those specified in Article 3(2) of Commission Implementing Regulation (EU) 2018/1976, the pilot shall hold at least a valid class 2 medical certificate;

(5) a commercial pilot licence (CPL), a multi-crew pilot licence (MPL) or an airline transport pilot licence (ATPL), the pilot shall hold a valid class 1 medical certificate.

(d) If a night rating is added to a PPL or LAPL, the licence holder shall be colour safe.

(e) If an instrument rating or basic instrument rating is added to a PPL, the licence holder shall undergo pure tone audiometry examinations in accordance with the periodicity and the standard required for class 1 medical certificate holders.

(f) A licence holder shall not at any time hold more than one medical certificate issued in accordance with this Annex (Part-MED).

## AMC1 MED.A.030 Medical certificates

*ED Decision 2019/002/R*

(a) A class 1 medical certificate includes the privileges and validities of class 2 and LAPL medical certificates.

(b) A class 2 medical certificate includes the privileges and validities of a LAPL medical certificate.

## MED.A.035 Application for a medical certificate

*Regulation (EU) 2019/27*

(a) Applications for a medical certificate shall be made in a form and manner established by the competent authority.

(b) Applicants for a medical certificate shall provide the AeMC, AME or GMP, as applicable, with:

(1) proof of their identity;

(2) a signed declaration:

(i) of medical facts concerning their medical history;

(ii) as to whether they have previously applied for a medical certificate or have undergone an aero-medical examination for a medical certificate and, if so, by whom and with what result;

(iii) as to whether they have ever been assessed as unfit or had a medical certificate suspended or revoked.

(c) When applying for a revalidation or renewal of the medical certificate, applicants shall present the most recent medical certificate to the AeMC, AME or GMP, as applicable, prior to the relevant aero-medical examinations.

## AMC1 MED.A.035 Application for a medical certificate

*ED Decision 2019/002/R*

Except for initial applicants, the AeMC, AME or GMP should not start the aero-medical examination for the issue of the medical certificate where applicants do not present the most recent medical certificate, unless relevant information is received from the medical assessor of the licensing authority.

## MED.A.040 Issuance, revalidation and renewal of medical certificates

*Regulation (EU) 2024/2076*

(a) A medical certificate shall only be issued, revalidated or renewed once the required aero-medical examinations and assessments, as applicable, have been completed and the applicant has been assessed as fit.

(b) *Initial issuance*

(1) Class 1 medical certificates shall be issued by an AeMC.

(2) Class 2 medical certificates shall be issued by an AeMC or an AME.

(3) LAPL medical certificates shall be issued by an AeMC or an AME. They may also be issued by a GMP if so permitted under the national law of the Member State of the licensing authority to which the application for the medical certificate has been made.

(c) *Revalidation and renewal*

(1) Class 1 and class 2 medical certificates shall be revalidated and renewed by an AeMC or an AME.

*[applicable until 12 February 2025 - Regulation (EU) 2019/27]*

(1) Class 1 and class 2 medical certificates shall be revalidated and renewed by an AeMC or an AME. Specifically, class 1 medical certificates for applicants who have reached the age of 60 and are involved in single-pilot HEMS operations shall be revalidated and renewed primarily by an AeMC or, at the discretion of the competent authority, by an experienced AME designated by the competent authority.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(2) LAPL medical certificates shall be revalidated and renewed by an AeMC or an AME. They may also be revalidated or renewed by a GMP if so permitted under the national law of the Member State of the licensing authority to which the application for the medical certificate has been made.

(d) The AeMC, AME or GMP shall only issue, revalidate or renew a medical certificate if both of the following conditions have been met:

(1) the applicant has provided them with a complete medical history and, if required by the AeMC, AME or GMP, with results of medical examinations and tests conducted by the applicant's physician or any medical specialists;

(2) the AeMC, AME or GMP has conducted the aero-medical assessment based on the medical examinations and tests as required for the relevant medical certificate to verify that the applicant complies with all the relevant requirements of this Annex (Part-MED).

(e) The AME, AeMC or, in the case of referral, the medical assessor of the licensing authority may require the applicant to undergo additional medical examinations and investigations when there is a clinical or epidemiological indication before the medical certificate is issued, revalidated or renewed.

(f) The medical assessor of the licensing authority may issue or reissue a medical certificate.

## MED.A.045 Validity, revalidation and renewal of medical certificates

*Regulation (EU) 2019/27*

(a) *Validity*

(1) Class 1 medical certificates shall be valid for a period of 12 months.

(2) By derogation from point (1), the period of validity of class 1 medical certificates shall be 6 months for licence holders who:

(i) are engaged in single-pilot commercial air transport operations carrying passengers and have reached the age of 40;

(ii) have reached the age of 60.

(3) Class 2 medical certificates shall be valid for a period of:

(i) 60 months, until the licence holder reaches the age of 40. A medical certificate issued prior to the licence holder reaching the age of 40 shall cease to be valid after the licence holder reaches the age of 42;

(ii) 24 months, for licence holders aged between 40 and 50. A medical certificate issued prior to the licence holder reaching the age of 50 shall cease to be valid after the licence holder reaches the age of 51;

(iii) 12 months, for licence holders aged above 50.

(4) LAPL medical certificates shall be valid for a period of:

(i) 60 months, until the licence holder reaches the age of 40. A medical certificate issued prior to the licence holder reaching the age of 40 shall cease to be valid after the licence holder reaches the age of 42;

(ii) 24 months, for licence holders aged above 40.

(5) The validity period of a medical certificate, including any associated examination or special investigation, shall be calculated from the date of the aero-medical examination in the case of initial issue and renewal, and from the expiry date of the previous medical certificate in the case of revalidation.

(b) *Revalidation*

Aero-medical examinations and assessments, as applicable, for the revalidation of a medical certificate may be undertaken up to 45 days prior to the expiry date of the medical certificate.

(c) *Renewal*

(1) If the holder of a medical certificate does not comply with point (b), a renewal examination and assessment, as applicable, shall be required.

(2) In the case of class 1 and class 2 medical certificates:

(i) if the medical certificate has expired for less than 2 years, a routine revalidation aero-medical examination shall be performed;

(ii) if the medical certificate has expired for more than 2 years but less than 5 years, the AeMC or AME shall only conduct the renewal aero-medical examination after assessment of the aero-medical records of the applicant;

(iii) if the medical certificate has expired for more than 5 years, the aero-medical examination requirements for initial issue shall apply and the assessment shall be based on the revalidation requirements.

(3) In the case of LAPL medical certificates, the AeMC, AME or GMP shall assess the medical history of the applicant and perform the aero-medical examinations and assessments, as applicable, in accordance with points MED.B.005 and MED.B.095.

## MED.A.046 Suspension or revocation of medical certificates

*Regulation (EU) 2019/27*

(a) A medical certificate may be suspended or revoked by the licensing authority.

(b) Upon suspension of the medical certificate, the holder shall return the medical certificate to the licensing authority on request of that authority.

(c) Upon revocation of the medical certificate, the holder shall immediately return the medical certificate to the licensing authority.

## MED.A.050 Referral

*Regulation (EU) 2019/27*

(a) If an applicant for a class 1 or class 2 medical certificate is referred to the medical assessor of the licensing authority in accordance with point MED.B.001, the AeMC or AME shall transfer the relevant medical documentation to the licensing authority.

(b) If an applicant for a LAPL medical certificate is referred to an AME or AeMC in accordance with point MED.B.001, the GMP shall transfer the relevant medical documentation to the AeMC or AME.

# SUBPART B – REQUIREMENTS FOR PILOT MEDICAL CERTIFICATES

## SECTION 1 – GENERAL

### MED.B.001 Limitations to medical certificates

*Regulation (EU) 2019/27*

(a) *Limitations to class 1 and class 2 medical certificates*

(1) If the applicant does not fully comply with the requirements for the relevant class of medical certificate but is considered to be not likely to jeopardise the safe exercise of the privileges of the applicable licence, the AeMC or AME shall:

(i) in the case of applicants for a class 1 medical certificate, refer the decision on fitness of the applicant to the medical assessor of the licensing authority as indicated in this Subpart;

(ii) in cases where a referral to the medical assessor of the licensing authority is not indicated in this Subpart, evaluate whether the applicant is able to perform his/her duties safely when complying with one or more limitations endorsed on the medical certificate and issue the medical certificate with limitation(s) as necessary;

(iii) in the case of applicants for a class 2 medical certificate, evaluate, in consultation with the medical assessor of the licensing authority as indicated in this Subpart, whether the applicant is able to perform his/her duties safely when complying with one or more limitations endorsed on the medical certificate and issue the medical certificate, with limitation(s) as necessary.

(2) The AeMC or AME may revalidate or renew a medical certificate with the same limitation(s) without referring to or consulting with the medical assessor of the licensing authority.

(b) *Limitations to LAPL medical certificates*

(1) If a GMP, after due consideration of the applicant's medical history, concludes that the applicant for a LAPL medical certificate does not fully meet the requirements for medical fitness, the GMP shall refer the applicant to an AeMC or AME, unless the applicant requires only limitation(s) related to the use of corrective lenses or to the period of validity of the medical certificate.

(2) If an applicant for a LAPL medical certificate has been referred in accordance with point (1), the AeMC or AME shall give due consideration to points MED.B.005 and MED.B.095, evaluate whether the applicant is able to perform his or her duties safely when complying with one or more limitations endorsed on the medical certificate and issue the medical certificate with limitation(s) as necessary. The AeMC or AME shall always consider the need to restrict the applicant from carrying passengers (operational passenger limitation, OPL).

(3) The GMP may revalidate or renew a LAPL medical certificate with the same limitation without referring the applicant to an AeMC or AME.

(c) When assessing whether a limitation is necessary, particular consideration shall be given to:

(1) whether accredited medical conclusion indicates that in special circumstances the applicant's failure to meet any requirement, whether numerical or otherwise, is such that the exercise of the privileges of the licence applied for is not likely to jeopardise flight safety;

(2) the applicant's ability, skill and experience relevant to the operation to be performed.

(d) *Operational limitation codes*

(1) Operational multi-pilot limitation (OML – class 1 only)

(i) When the holder of a CPL, ATPL or MPL does not fully meet the requirements for a class 1 medical certificate and has been referred to a medical assessor of the licensing authority, that medical assessor shall assess whether the medical certificate may be issued with an OML 'valid only as or with qualified co-pilot'.

(ii) The holder of a medical certificate with an OML shall only operate an aircraft in multi-pilot operations when the other pilot is fully qualified on the relevant class and type of aircraft, is not subject to an OML and has not attained the age of 60 years.

(iii) The OML for class 1 medical certificates shall be initially imposed and only removed by the medical assessor of the licensing authority.

(2) Operational safety pilot limitation (OSL – class 2 and LAPL privileges)

(i) The holder of a medical certificate with an OSL shall only operate an aircraft if another pilot fully qualified to act as pilot-in-command on the relevant class and type of aircraft is carried on board, the aircraft is fitted with dual controls and the other pilot occupies a seat at the controls.

(ii) The OSL for class 2 medical certificates may be imposed and removed either by the medical assessor of the licensing authority, or by an AeMC or an AME in consultation with the medical assessor of the licensing authority.

(iii) The OSL for LAPL medical certificates may be imposed and removed by the medical assessor of the licensing authority, an AeMC or an AME.

(3) Operational passenger limitation (OPL – class 2 and LAPL privileges)

(i) The holder of a medical certificate with an OPL shall only operate an aircraft without passengers on board.

(ii) The OPL for class 2 medical certificates may be imposed and removed either by the medical assessor of the licensing authority, or by an AeMC or an AME in consultation with the medical assessor of the licensing authority.

(iii) The OPL for LAPL medical certificates may be imposed and removed by the medical assessor of the licensing authority, an AeMC or an AME.

(4) Operational pilot restriction limitation (ORL – class 2 and LAPL privileges)

(i) The holder of a medical certificate with an ORL shall only operate an aircraft if one of the two following conditions have been met:

(A) another pilot fully qualified to act as pilot-in-command on the relevant class and type of aircraft is on board the aircraft, the aircraft is fitted with dual controls and the other pilot occupies a seat at the controls;

(B) there are no passengers on board the aircraft.

(ii) The ORL for class 2 medical certificates may be imposed and removed either by the medical assessor of the licensing authority, or by an AeMC or AME in consultation with the medical assessor of the licensing authority.

(iii) The ORL for LAPL medical certificates may be imposed and removed by the medical assessor of the licensing authority, an AeMC or an AME.

(5) Special restriction as specified (SSL)

The SSL on a medical certificate shall be followed by a description of the limitation.

(e) Any other limitation may be imposed on the holder of a medical certificate by the medical assessor of the licensing authority, AeMC, AME or GMP, as applicable, if required to ensure flight safety.

(f) Any limitation imposed on the holder of a medical certificate shall be specified therein.

## AMC1 MED.B.001 Limitations to medical certificates

*ED Decision 2019/002/R*

**GENERAL**

(a) An AeMC or AME may refer the decision on fitness of an applicant to the medical assessor of the licensing authority in borderline cases or where fitness is in doubt.

(b) In cases where a fit assessment may only be considered with a limitation, the AeMC, AME, GMP or the medical assessor of the licensing authority should evaluate the medical condition of the applicant in consultation with flight operations and other experts, if necessary.

(c) Initial application of limitations

(1) The limitations TML, VDL, VML, VNL and VCL, as listed in AMC2 MED.B.001(a), may be imposed by an AME or an AeMC for class 1, class 2, and LAPL medical certificates, or a GMP for LAPL medical certificates.

(2) All other limitations listed in AMC2 MED.B.001(a) should only be imposed:

(i) for class 1 medical certificates, by the medical assessor of the licensing authority where a referral is required according to MED.B.001;

(ii) for class 2 medical certificates, by the AME or AeMC in consultation with the medical assessor of the licensing authority where consultation is required according to MED.B.001;

(iii) for LAPL medical certificates, by an AME or AeMC.

(d) Removal of limitations

(1) For class 1 medical certificates, all limitations should only be removed by the medical assessor of the licensing authority.

(2) For class 2 medical certificates, limitations may be removed by the medical assessor of the licensing authority or by an AeMC or AME in consultation with the medical assessor of the licensing authority.

(3) For LAPL medical certificates, limitations may be removed by an AeMC or AME.

## AMC2 MED.B.001 Limitations to medical certificates

*ED Decision 2019/002/R*

**LIMITATION CODES**

(a) The following abbreviations for limitations codes should be used on the medical certificates as applicable:

| Code | Limitation |
|---|---|
| TML | Limited period of validity of the medical certificate |
| VDL | Valid only with correction for defective distant vision |
| VML | Valid only with correction for defective distant, intermediate and near vision |
| VNL | Valid only with correction for defective near vision |
| CCL | Correction by means of contact lenses |
| VCL | Valid by day only |
| RXO | Specialist ophthalmological examination(s) |
| SIC | Specific medical examination(s) |
| HAL | Valid only when hearing aids are worn |
| APL | Valid only with approved prosthesis |
| AHL | Valid only with approved hand controls |
| OML | Valid only as, or with, a qualified co-pilot |
| OCL | Valid only as a qualified co-pilot |
| OSL | Valid only with a safety pilot and in aircraft with dual controls |
| OPL | Valid only without passengers |
| ORL | Valid only with a safety pilot if passengers are carried |
| OAL | Restricted to demonstrated aircraft type |
| SSL | Special restriction(s) as specified |

(b) The abbreviations for the limitation codes should be explained to the holder of a medical certificate as follows:

(1) TML Time limitation

The period of validity of the medical certificate is limited to the duration as shown on the medical certificate. This period of validity commences on the date of the medical examination. Any period of validity remaining on the previous medical certificate is no longer valid. The holder of the medical certificate should present themselves for re-examination when advised and should follow any medical recommendations.

(2) VDL Wear corrective lenses and carry a spare set of spectacles

Correction for defective distant vision: whilst exercising the privileges of the licence, the holder of the medical certificate should wear spectacles or contact lenses that correct for

defective distant vision as examined and approved by the AeMC, AME or GMP. Contact lenses may not be worn until cleared to do so by the AeMC, AME or GMP. A spare set of spectacles, approved by the AeMC, AME or GMP, should be readily available.

(3) VML Wear multifocal spectacles and carry a spare set of spectacles

Correction for defective distant, intermediate and near vision: whilst exercising the privileges of the licence, the holder of the medical certificate should wear spectacles that correct for defective distant, intermediate and near vision as examined and approved by the AeMC, AME or GMP. Contact lenses or full frame spectacles, when either correct for near vision only, may not be worn. A spare set of spectacles, approved by the AeMC, AME or GMP, should be readily available.

(4) VNL Have available corrective spectacles and carry a spare set of spectacles

Correction for defective near vision: whilst exercising the privileges of the licence, the holder of the medical certificate should have readily available spectacles that correct for defective near vision as examined and approved by the AeMC, AME or GMP. Contact lenses or full frame spectacles, when either correct for near vision only, may not be worn. A spare set of spectacles, approved by the AeMC, AME or GMP, should be readily available.

(5) CCL Wear contact lenses that correct for defective distant vision

Correction for defective distant vision: whilst exercising the privileges of the licence, the holder of a medical certificate should wear contact lenses that correct for defective distant vision, as examined and approved by the AeMC, AME or GMP. A spare set of similarly correcting spectacles, approved by the AeMC, AME or GMP, should be readily available for immediate use whilst exercising the privileges of the licence.

(6) VCL Valid by day only

This limitation allows holders of a class 2 or LAPL medical certificate with varying degrees of colour deficiency, to exercise the privileges of their licence by daytime only.

(7) RXO Specialist ophthalmological examination(s)

Specialist ophthalmological examination(s), other than the examinations stipulated in Part-MED, are required for a significant reason.

(8) SIC Specific regular medical examination(s) contact the medical assessor of the licensing authority

This limitation requires the AeMC, or AME to contact the medical assessor of the licensing authority before embarking upon a revalidation or renewal aero-medical assessment. The limitation is likely to concern a medical history or additional examination(s) which the AeMC or AME should be aware of prior to undertaking the assessment.

(9) HAL Wear hearing aid(s)

Whilst exercising the privileges of the licence, the holder of the medical certificate should use hearing aid(s) that compensate for defective hearing as examined and approved by the AeMC or AME. A spare set of batteries should be readily available.

(10) APL Valid only with approved prosthesis

This limitation applies to the holder of a medical certificate with a musculoskeletal condition when a medical flight test or a flight simulator test has shown that the use of a prosthesis is required to safely exercise the privileges of the licence. The prosthesis to be used should be approved.

(11) AHL Valid only with approved hand controls

This limitation applies to the holder of a medical certificate who has a limb deficiency or other anatomical problem which had been shown by a medical flight test or flight simulator testing to be acceptable but to require the aircraft to be equipped with suitable, approved hand controls.

(12) OML Valid only as or with a qualified co-pilot

This limitation applies to holders of a class 1 medical certificate who do not fully meet the aero-medical requirements for single-pilot operations, but are fit for multi-pilot operations. Refer to MED.B.001(d)(1).

(13) OCL Valid only as a qualified co-pilot

This limitation is an extension of the OML and are restricted to the role of co-pilot.

(14) OSL Valid only with a safety pilot and in aircraft with dual controls

This limitation applies to holders of a class 2 or a LAPL medical certificate only. The safety pilot should be made aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and should be prepared to take over the aircraft controls during flight. Refer to MED.B.001(d)(2).

(15) OPL Valid only without passengers

This limitation applies to holders of a class 2 or LAPL medical certificate with a medical condition that may lead to an increased level of risk to flight safety when exercising the privileges of the licence. This limitation is to be applied when this risk is not acceptable for the carriage of passengers. Refer to MED.B.001(d)(3).

(16) ORL Valid only with a safety pilot if passengers are carried and in aircraft with dual controls

This limitation applies to holders of a class 2 or LAPL medical certificate with a medical condition that may lead to an increased level of risk to flight safety when exercising the privileges of the licence. The safety pilot, if carried, should be made aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and should be prepared to take over the aircraft controls during flight. Refer to MED.B.001(d)(4).

(17) OAL Restricted to demonstrated aircraft type

This limitation applies to a the holder of a medical certificate who has a limb deficiency or other medical problem which had been shown by a medical flight test or flight simulator testing to be acceptable but to require a restriction to a specific class and type of aircraft.

(18) SSL Special restriction(s) as specified

This limitation may be considered when an individually specified limitation, not defined in this AMC, is appropriate to mitigate an increased level of risk to flight safety. The description of the SSL should be entered on the medical certificate or in a separate document to be carried with the medical certificate.

## MED.B.005 General medical requirements

*Regulation (EU) 2024/2076*

Applicants for a medical certificate shall be assessed in accordance with the detailed medical requirements set out in Sections 2 and 3.

They shall, in addition, be assessed as unfit where they have any of the following medical conditions which entails a degree of functional incapacity which is likely to interfere with the safe exercise of the privileges of the licence applied for or could render the applicant likely to become suddenly unable to exercise those privileges:

(a) abnormality, either congenital or acquired;

(b) active, latent, acute or chronic disease or disability;

(c) wound, injury or sequelae from operation;

(d) effect or side effect of any prescribed or non-prescribed therapeutic, diagnostic or preventive medication taken.

In their examination AMEs shall give proper consideration to the degenerative effects of ageing on the body systems.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

# SECTION 2 – MEDICAL REQUIREMENTS FOR CLASS 1 AND CLASS 2 MEDICAL CERTIFICATES

## MED.B.010 Cardiovascular System

*Regulation (EU) 2024/2076*

(a) *Examination*

(1) A standard 12-lead resting electrocardiogram (ECG) and report shall be completed when clinically indicated and at the following moments:

(i) for a class 1 medical certificate, at the initial examination, then every 5 years until age 30, every 2 years until age 40, annually until age 50, and at all revalidation or renewal examinations thereafter;

(ii) for a class 2 medical certificate, at the initial examination, at the first examination after age 40 and then at the first examination after age 50, and every 2 years thereafter.

(2) An extended cardiovascular assessment shall be required when clinically indicated.

(3) For a class 1 medical certificate, an extended cardiovascular assessment shall be completed at the first revalidation or renewal examination after age 65 and every 4 years thereafter.

*[applicable until 12 February 2025 - Regulation* (EU) *2019/27]*

(3) For a class 1 medical certificate, an extended cardiovascular assessment shall be completed at the first revalidation or renewal examination after the age of 65 and every 4 years thereafter. For applicants involved in single-pilot HEMS operations, an extended cardiovascular assessment shall be completed at the first revalidation or renewal examination after the age of 60 and subject to a cardiovascular risk factor assessment thereafter.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(4) For a class 1 medical certificate, estimation of serum lipids, including cholesterol, shall be required at the initial examination, and at the first examination after having reached the age of 40.

*[applicable until 12 February 2025 - Regulation (EU) 2019/27]*

(4) For a class 1 medical certificate, estimation of serum lipids, including cholesterol fractions, shall be required at the initial examination, and at the first examination after having reached the age of 40.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(b) *Cardiovascular System – General*

(1) Applicants for a class 1 medical certificate with any of the following medical conditions shall be assessed as unfit:

(i) aneurysm of the thoracic or supra-renal abdominal aorta, before surgery;

(ii) significant functional or symptomatic abnormality of any of the heart valves;

(iii) heart or heart/lung transplantation.;

(iv) symptomatic hypertrophic cardiomyopathy.

(2) Before further consideration is given to their application, applicants for a class 1 medical certificate with a documented medical history or diagnosis of any of the following medical conditions shall be referred to the medical assessor of the licensing authority:

(i) peripheral arterial disease before or after surgery;

(ii) aneurysm of the thoracic or supra-renal abdominal aorta after surgery;

(iii) aneurysm of the infra-renal abdominal aorta before or after surgery;

(iv) functionally insignificant cardiac valvular abnormalities;

(v) after cardiac valve surgery;

(vi) abnormality of the pericardium, myocardium or endocardium;

(vii) congenital abnormality of the heart, before or after corrective surgery;

(viii) vasovagal syncope of uncertain cause;

(ix) arterial or venous thrombosis;

(x) pulmonary embolism;

(xi) cardiovascular condition requiring systemic anticoagulant therapy.

(3) Applicants for a class 2 medical certificate with an established diagnosis of one of the conditions specified in points (1) and (2) shall be evaluated by a cardiologist before they may be assessed as fit, in consultation with the medical assessor of the licensing authority.

(4) Applicants with cardiac disorders other than those specified in points (1) and (2) may be assessed as fit subject to satisfactory cardiological evaluation.

(5) A cardiovascular risk factor assessment shall form part of examinations for class 1 and class 2 medical certificates at the first examination after reaching the age of 40 and at regular intervals thereafter.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(c) *Blood Pressure*

(1) Applicants' blood pressure shall be recorded at each examination.

(2) Applicants whose's blood pressure is not within normal limits shall be further assessed with regard to their cardiovascular condition and medication with a view to determining whether they are to be assessed as unfit in accordance with points (3) and (4).

(3) Applicants for a class 1 medical certificate with any of the following medical conditions shall be assessed as unfit:

(i) symptomatic hypotension;

(ii) blood pressure at examination consistently exceeding 160 mmHg systolic or 95 mmHg diastolic, with or without treatment.

(4) Applicants who have commenced the use of medication for the control of blood pressure shall be assessed as unfit until the absence of significant side effects has been established.

(d) *Coronary Artery Disease*

(1) Before further consideration is given to their application, applicants for a class 1 medical certificate with any of the following medical conditions shall be referred to the medical assessor of the licensing authority and undergo cardiological evaluation to exclude myocardial ischaemia:

(i) suspected myocardial ischaemia;

(ii) asymptomatic minor coronary artery disease requiring no anti-anginal treatment.

(2) Before further consideration is given to their application, applicants for a class 2 medical certificate with any of the medical conditions set out in point (1) shall undergo satisfactory cardiological evaluation.

(3) Applicants with any of the following medical conditions shall be assessed as unfit:

(i) myocardial ischaemia;

(ii) symptomatic coronary artery disease;

(iii) symptoms of coronary artery disease controlled by medication.

(4) Applicants for the initial issue of a class 1 medical certificate with a medical history or diagnosis of any of the following medical conditions shall be assessed as unfit:

(i) myocardial ischaemia;

(ii) myocardial infarction;

(iii) revascularisation or stenting for coronary artery disease.

(5) Before further consideration is given to their application, applicants for a class 2 medical certificate who are asymptomatic following myocardial infarction or surgery for coronary artery disease shall undergo satisfactory cardiological evaluation, in consultation with the medical assessor of the licensing authority. Such applicants for the revalidation of a class 1 medical certificate shall be referred to the medical assessor of the licensing authority.

(e) *Rhythm/Conduction Disturbances*

(1) Applicants with any of the following medical conditions shall be assessed as unfit:

(i) symptomatic sinoatrial disease;

(ii) complete atrioventricular block;

(iii) symptomatic QT prolongation;

(iv) an automatic implantable defibrillating system;

(v) a ventricular anti-tachycardia pacemaker.

(2) Before further consideration is given to their application, applicants for a class 1 medical certificate havingany significant disturbance of cardiac conduction or rhythm, including any of the following, shall be referred to the medical assessor of the licensing authority:

(i) disturbance of supraventricular rhythm, including intermittent or established sinoatrial dysfunction, atrial fibrillation and/or flutter and asymptomatic sinus pauses;

(ii) complete left bundle branch block;

(iii) Mobitz type 2 atrioventricular block;

(iv) broad and/or narrow complex tachycardia;

(v) ventricular pre-excitation;

(vi) asymptomatic QT prolongation;

(vii) Brugada pattern on electrocardiography.

(3) Before further consideration is given to their application, applicants for a class 2 medical certificate with any of the medical conditions specified in point (2) shall undergo satisfactory cardiological evaluation, in consultation with the medical assessor of the licensing authority.

(4) Applicants with any of the following medical conditions may be assessed as fit subject to satisfactory cardiological evaluation and in the absence of any other abnormality:

(i) incomplete bundle branch block;

(ii) complete right bundle branch block;

(iii) stable left axis deviation;

(iv) asymptomatic sinus bradycardia;

(v) asymptomatic sinus tachycardia;

(vi) asymptomatic isolated uniform supra-ventricular or ventricular ectopic complexes;

(vii) first degree atrioventricular block;

(viii) Mobitz type 1 atrioventricular block.

(5) Applicants with a medical history of any of the following medical conditions shall undergo satisfactory cardiovascular evaluation before they may be assessed as fit:

(i) ablation therapy;

(ii) pacemaker implantation.

Such applicants for a class 1 medical certificate shall be referred to the medical assessor of the licensing authority. Such applicants for a class 2 medical certificate shall be assessed in consultation with the medical assessor of the licensing authority.

## AMC1 MED.B.010 Cardiovascular system

*ED Decision 2019/002/R*

(a) Examination

Exercise electrocardiography

An exercise ECG when required as part of a cardiovascular assessment should be symptom limited and completed to a minimum of Bruce Stage IV or equivalent.

(b) General

(1) Cardiovascular risk factor assessment

(i) Serum lipid estimation is case finding and significant abnormalities should be reviewed, investigated and supervised by the AeMC or AME in consultation with the medical assessor of the licensing authority.

(ii) Applicants with an accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) should undergo a cardiovascular evaluation by the AeMC or AME, if necessary in consultation with the medical assessor of the licensing authority.

(2) Cardiovascular assessment

(i) Reporting of resting and exercise electrocardiograms should be by the AME or an accredited specialist.

(ii) The extended cardiovascular assessment should be undertaken at an AeMC or may be delegated to a cardiologist.

(c) Peripheral arterial disease

If there is no significant functional impairment, a fit assessment may be considered provided:

(1) applicants without symptoms of coronary artery disease have reduced any vascular risk factors to an appropriate level;

(2) applicants should be on appropriate secondary prevention treatment;

(3) exercise electrocardiography is satisfactory. Further tests may be required which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(d) Aortic aneurysm

(1) Applicants with an aneurysm of the infra-renal abdominal aorta of less than 5 cm in diameter may be assessed as fit before surgery, with an OML subject to satisfactory evaluation by a cardiologist. Follow-up by ultra-sound scans or other imaging techniques, as necessary, should be determined by the medical assessor of the licensing authority.

(2) Applicants may be assessed as fit with an OML after surgery for an aneurysm of the thoracic or abdominal aorta if the blood pressure and cardiovascular evaluation is satisfactory. Regular evaluations by a cardiologist should be carried out.

(e) Cardiac valvular abnormalities

(1) Applicants with previously unrecognised cardiac murmurs should undergo evaluation by a cardiologist and assessment by the medical assessor of the licensing authority. If considered significant, further investigation should include at least 2D Doppler echocardiography or equivalent imaging.

(2) Applicants with minor cardiac valvular abnormalities may be assessed as fit. Applicants with significant abnormality of any of the heart valves should be assessed as unfit.

(3) Aortic valve disease

(i) Applicants with a bicuspid aortic valve may be assessed as fit if no other cardiac or aortic abnormality is demonstrated. Follow-up with echocardiography, as necessary, should be determined by the medical assessor of the licensing authority.

(ii) Applicants with aortic stenosis may be assessed as fit provided the left ventricular function is intact and the mean pressure gradient is less than 20 mmHg. Applicants with an aortic valve orifice with indexation on the body surface of more than 0.6 $cm^2/m^2$ and a mean pressure gradient above 20 mmHg, but not greater than 50 mmHg, may be assessed as fit with an OML. Follow-up with 2D Doppler echocardiography, as necessary, should be determined by the medical assessor of

the licensing authority in all cases. Alternative measurement techniques with equivalent ranges may be used. Regular evaluation by a cardiologist should be considered. Applicants with a history of systemic embolism or significant dilatation of the thoracic aorta should be assessed as unfit.

(iii) Applicants with trivial aortic regurgitation may be assessed as fit. A greater degree of aortic regurgitation should require an OML. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Follow-up, as necessary, should be determined by the medical assessor of the licensing authority.

(4) Mitral valve disease

(i) Asymptomatic applicants with an isolated mid-systolic click due to mitral leaflet prolapse may be assessed as fit.

(ii) Applicants with rheumatic mitral stenosis should normally be assessed as unfit.

(iii) Applicants with minor regurgitation may be assessed as fit. Periodic cardiological review should be determined by the medical assessor of the licensing authority.

(iv) Applicants with moderate mitral regurgitation may be considered as fit with an OML if the 2D Doppler echocardiogram demonstrates satisfactory left ventricular dimensions and satisfactory myocardial function is confirmed by exercise electrocardiography. Periodic cardiological review should be required, as determined by the medical assessor of the licensing authority.

(v) Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter or evidence of systolic impairment should be assessed as unfit.

(f) Valvular surgery

Applicants who have undergone cardiac valve replacement or repair should be assessed as unfit. A fit assessment may be considered in the following cases:

(1) Mitral leaflet repair for prolapse is compatible with a fit assessment, provided post-operative investigations reveal satisfactory left ventricular function without systolic or diastolic dilation and no more than minor mitral regurgitation.

(2) Asymptomatic applicants with a tissue valve or with a mechanical valve who, at least 6 months following surgery, are taking no cardioactive medication may be considered for a fit assessment with an OML. Investigations which demonstrate normal valvular and ventricular configuration and function should have been completed as demonstrated by:

(i) a satisfactory symptom limited exercise ECG. Myocardial perfusion imaging/stress echocardiography should be required if the exercise ECG is abnormal or any coronary artery disease is suspected;

(ii) a 2D Doppler echocardiogram showing no significant selective chamber enlargement, a tissue valve with minimal structural alteration and a normal Doppler blood flow, and no structural or functional abnormality of the other heart valves. Left ventricular fractional shortening should be normal.

Follow-up with exercise ECG and 2D echocardiography, as necessary, should be determined by the medical assessor of the licensing authority.

(3) Where anticoagulation is needed after valvular surgery, a fit assessment with an OML may be considered if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 international normalised ratio (INR) values are documented, of which at least 4 are within the INR target range. The INR target range should be determined by the type of surgery performed.

(g) Thromboembolic disorders

Applicants with arterial or venous thrombosis or pulmonary embolism should be assessed as unfit. A fit assessment with an OML may be considered after a period of stable anticoagulation as prophylaxis, after review by the medical assessor of the licensing authority. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range and the haemorrhagic risk is acceptable. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an OML may be considered after review by the medical assessor of the licensing authority after a stabilisation period of 3 months. Applicants with pulmonary embolism should also be evaluated by a cardiologist. Following cessation of anticoagulant therapy, for any indication, applicants should undergo a re-assessment by the medical assessor of the licensing authority.

(h) Other cardiac disorders

(1) Applicants with a primary or secondary abnormality of the pericardium, myocardium or endocardium should be assessed as unfit. A fit assessment may be considered following complete resolution and satisfactory cardiological evaluation which may include 2D Doppler echocardiography, exercise ECG and/or myocardial perfusion imaging/stress echocardiography and 24-hour ambulatory ECG. Coronary angiography may be indicated. Frequent review and an OML may be required after fit assessment.

(2) Applicants with a congenital abnormality of the heart should be assessed as unfit. Applicants following surgical correction or with minor abnormalities that are functionally unimportant may be assessed as fit following cardiological evaluation. No cardioactive medication is acceptable. Investigations may include 2D Doppler echocardiography, exercise ECG and 24-hour ambulatory ECG. The potential hazard of any medication should be considered as part of the assessment. Particular attention should be paid to the potential for the medication to mask the effects of the congenital abnormality before or after surgery. Regular cardiological evaluations should be carried out.

(i) Syncope

(1) In the case of a single episode of vasovagal syncope which can be explained and is compatible with flight safety, a fit assessment may be considered.

(2) Applicants with a history of recurrent vasovagal syncope should be assessed as unfit. A fit assessment may be considered after a 6-month period without recurrence, provided cardiological evaluation is satisfactory. Such evaluation should include:

(i) a satisfactory symptom limited 12 lead exercise ECG to Bruce Stage IV, or equivalent. If the exercise ECG is abnormal, myocardial perfusion imaging/stress echocardiography or equivalent test should be carried out;

(ii) a 2D Doppler echocardiogram showing neither significant selective chamber enlargement nor structural or functional abnormality of the heart, valves or myocardium;

(iii) a 24-hour ambulatory ECG recording showing no conduction disturbance, complex or sustained rhythm disturbance or evidence of myocardial ischaemia.

(3) A tilt test, or equivalent, carried out to a standard protocol showing no evidence of vasomotor instability may be required.

(4) Neurological review should be required.

(5) An OML should be required until a period of 5 years has elapsed without recurrence. The medical assessor of the licensing authority may determine a shorter or longer period of OML according to the individual circumstances of the case.

(6) Applicants who experienced loss of consciousness without significant warning should be assessed as unfit.

(j) Blood pressure

(1) The diagnosis of hypertension should require cardiovascular evaluation to include potential vascular risk factors.

(2) Anti-hypertensive treatment should be agreed by the medical assessor of the licensing authority. Acceptable medication may include:

(i) non-loop diuretic agents;

(ii) ACE inhibitors;

(iii) angiotensin II receptor blocking agents (sartans);

(iv) channel calcium blocking agents;

(v) certain (generally hydrophilic) beta-blocking agents.

(3) Following initiation of medication for the control of blood pressure, applicants should be re-assessed to verify that satisfactory control has been achieved and the treatment is compatible with the safe exercise of the privileges of the applicable licence(s).

(k) Coronary artery disease

(1) Chest pain of uncertain cause should require full investigation. Applicants with angina pectoris should be assessed as unfit, whether or not it is alleviated by medication.

(2) In suspected asymptomatic coronary artery disease, exercise electrocardiography should be required. Further tests may be required, which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(3) Applicants with evidence of exercise-induced myocardial ischaemia should be assessed as unfit.

(4) After an ischaemic cardiac event or revascularisation procedure, applicants should have reduced cardiovascular risk factors to an appropriate level. Medication, when used to control cardiac symptoms, is not acceptable. All applicants should be on appropriate secondary prevention treatment.

(i) A coronary angiogram obtained around the time of, or during, the ischaemic myocardial event or revasculisation procedure and a complete, detailed clinical report of the ischaemic event and of any operative procedures should be made available to the medical assessor of the licensing authority:

(A) there should be no stenosis more than 50 % in any major untreated vessel, in any vein or artery graft or at the site of an angioplasty/stent, except in a vessel subtending a myocardial infarction;

(B) the whole coronary vascular tree should be assessed as satisfactory by a cardiologist, and particular attention should be paid to multiple stenoses and/or multiple revascularisations;

(C) Applicants with an untreated stenosis greater than 30 % in the left main or proximal left anterior descending coronary artery should be assessed as unfit.

(ii) At least 6 months from the ischaemic myocardial event or revascularisation procedure, the following investigations should be completed (equivalent tests may be substituted):

(A) an exercise ECG showing neither evidence of myocardial ischaemia nor rhythm or conduction disturbance;

(B) an echocardiogram showing satisfactory left ventricular function with no important abnormality of wall motion (such as dyskinesia or akinesia) and a left ventricular ejection fraction of 50 % or more;

(C) in cases of angioplasty/stenting, a myocardial perfusion scan or stress echocardiogram, or equivalent test, which should show no evidence of reversible myocardial ischaemia. If there is any doubt about myocardial perfusion in other cases (infarction or bypass grafting) a perfusion scan, or equivalent test, should also be carried out;

(D) further investigations, such as a 24-hour ECG, may be necessary to assess the risk of any significant rhythm disturbance.

(iii) Follow-up should be annual (or more frequently, if necessary) to ensure that there is no deterioration of the cardiovascular status. It should include a review by a cardiologist, exercise ECG and cardiovascular risk assessment. Additional investigations may be required by the medical assessor of the licensing authority.

(A) After coronary artery bypass grafting, a myocardial perfusion scan, or equivalent test, should be performed if there is any indication, and in all cases within 5 years from the procedure.

(B) In all cases, coronary angiography should be considered at any time if symptoms, signs or non-invasive tests indicate myocardial ischaemia.

(iv) Successful completion of the 6-month or subsequent review will allow a fit assessment with an OML.

(l) Rhythm and conduction disturbances

(1) Applicants with significant rhythm or conduction disturbance should undergo evaluation by a cardiologist before a fit assessment with an OML, as necessary, may be considered. Appropriate follow-up should be carried out at regular intervals. Such evaluation should include:

(i) exercise ECG to the Bruce protocol or equivalent. Bruce stage 4 should be achieved and no significant abnormality of rhythm or conduction, or evidence of myocardial ischaemia should be demonstrated. Withdrawal of cardioactive medication prior to the test should normally be required;

(ii) 24-hour ambulatory ECG which should demonstrate no significant rhythm or conduction disturbance;

(iii) 2D Doppler echocardiogram which should show no significant selective chamber enlargement or significant structural or functional abnormality, and a left ventricular ejection fraction of at least 50 %.

Further evaluation may include (equivalent tests may be substituted):

(iv) 24-hour ECG recording repeated as necessary;

(v) electrophysiological study;

(vi) myocardial perfusion imaging;

(vii) cardiac magnetic resonance imaging (MRI);

(viii) coronary angiogram.

(2) Applicants with frequent or complex forms of supra ventricular or ventricular ectopic complexes require full cardiological evaluation.

(3) Where anticoagulation is needed for a rhythm disturbance, a fit assessment with an OML may be considered if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an OML may be considered after review by the medical assessor of the licensing authority after a stabilisation period of 3 months.

(4) Ablation

Applicants who have undergone ablation therapy should be assessed as unfit. A fit assessment may be considered following successful catheter ablation and should require an OML for at least one year, unless an electrophysiological study, undertaken at a minimum of 2 months after the ablation, demonstrates satisfactory results. For those whose long-term outcome cannot be assured by invasive or non-invasive testing, an additional period with an OML and/or observation may be necessary.

(5) Supraventricular arrhythmias

Applicants with significant disturbance of supraventricular rhythm, including sinoatrial dysfunction, whether intermittent or established, should be assessed as unfit. A fit assessment may be considered if cardiological evaluation is satisfactory.

(i) Atrial fibrillation/flutter

(A) For initial applicants, a fit assessment should be limited to those with a single episode of arrhythmia which is considered by the medical assessor of the licensing authority to be unlikely to recur.

(B) For revalidation, applicants may be assessed as fit if cardiological evaluation is satisfactory and the stroke risk is sufficiently low. A fit assessment with an OML may be considered after a period of stable anticoagulation as prophylaxis, after review by the medical assessor of the licensing authority. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an OML may be considered after review

by the medical assessor of the licensing authority after a stabilisation period of 3 months.

(ii) Applicants with asymptomatic sinus pauses up to 2.5 seconds on resting electrocardiography may be assessed as fit if exercise electrocardiography, echocardiography and 24-hour ambulatory ECG are satisfactory.

(iii) Applicants with symptomatic sino-atrial disease should be assessed as unfit.

(6) Mobitz type 2 atrio-ventricular block

Applicants with Mobitz type 2 AV block should require full cardiological evaluation and may be assessed as fit in the absence of distal conducting tissue disease.

(7) Complete right bundle branch block

(i) Applicants with complete right bundle branch block should undergo a cardiological evaluation on first presentation. A fit assessment may be considered if there is no underlying pathology.

(ii) Applicants with bifascicular block may be assessed as fit with an OML after a satisfactory cardiological evaluation. The OML may be considered for removal if an electrophysiological study demonstrates no infra-Hissian block, or a 3-year period of satisfactory surveillance has been completed.

(8) Complete left bundle branch block

(i) A fit assessment may be considered subject to satisfactory cardiological evaluation and a 3-year period with an OML, and without an OML after 3 years of surveillance and satisfactory cardiological evaluation.

(ii) Investigation of the coronary arteries is necessary for applicants over age 40.

(9) Ventricular pre-excitation

(i) Asymptomatic initial applicants with pre-excitation may be assessed as fit if an electrophysiological study, including adequate drug-induced autonomic stimulation reveals no inducible re-entry tachycardia and the existence of multiple pathways is excluded.

(ii) Asymptomatic applicants with pre-excitation may be assessed as fit at revalidation with limitation(s) as appropriate. Limitations may not be necessary if an electrophysiological study, including adequate drug-induced autonomic stimulation, reveals no inducible re-entry tachycardia and the existence of multiple accessory pathways is excluded.

(10) Pacemaker

Applicants with a subendocardial pacemaker should be assessed as unfit. A fit assessment with an OML may be considered at revalidation no sooner than 3 months after insertion provided:

(i) there is no other disqualifying condition;

(ii) a bipolar lead system, programmed in bipolar mode without automatic mode change has been used;

(iii) the applicant is not pacemaker dependent; and

(iv) the applicant has a follow-up at least every 12 months, including a pacemaker check.

(11) QT prolongation

Applicants with asymptomatic QT prolongation may be assessed as fit with an OML subject to satisfactory cardiological evaluation.

(12) Brugada pattern on electrocardiography

Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitations as appropriate, subject to satisfactory cardiological evaluation.

## AMC2 MED.B.010 Cardiovascular system

*ED Decision 2019/002/R*

(a) Examination

Exercise electrocardiography

An exercise ECG when required as part of a cardiovascular assessment should be symptom-limited and completed to a minimum of Bruce Stage IV or equivalent.

(b) General

(1) Cardiovascular risk factor assessment

Applicants with an accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) should undergo a cardiovascular evaluation by the AeMC or AME.

(2) Cardiovascular assessment

Reporting of resting and exercise electrocardiograms should be by the AME or an accredited specialist.

(c) Peripheral arterial disease

A fit assessment may be considered for an applicant with peripheral arterial disease, or after surgery for peripheral arterial disease, provided there is no significant functional impairment, any vascular risk factors have been reduced to an appropriate level, the applicant is receiving acceptable secondary prevention treatment, and there is no evidence of myocardial ischaemia.

(d) Aortic aneurysm

(1) Applicants with an aneurysm of the infra-renal abdominal aorta of less than 5 cm in diameter may be assessed as fit, subject to satisfactory cardiological evaluation. Regular cardiological evaluations should be carried out.

(2) Applicants with an aneurysm of the thoracic or supra-renal abdominal aorta of less than 5 cm in diameter may be assessed as fit with an ORL or OSL, subject to satisfactory cardiological evaluation. Regular follow-up should be carried out.

(3) Applicants may be assessed as fit after surgery for an infra-renal abdominal aortic aneurysm, subject to satisfactory cardiological evaluation. Regular cardiological evaluations should be carried out.

(4) Applicants may be assessed as fit with an ORL or OSL after surgery for a thoracic or supra-renal abdominal aortic aneurysm, subject to satisfactory cardiological evaluation. Regular cardiological evaluations should be carried out.

(e) Cardiac valvular abnormalities

(1) Applicants with previously unrecognised cardiac murmurs should undergo further cardiological evaluation.

(2) Applicants with minor cardiac valvular abnormalities may be assessed as fit.

(3) Aortic valve disease

(i) Applicants with a bicuspid aortic valve may be assessed as fit if no other cardiac or aortic abnormality is demonstrated. Follow-up with echocardiography, as necessary, should be determined in consultation with the medical assessor of the licensing authority.

(ii) Applicants with aortic stenosis may be assessed as fit provided the left ventricular function is intact and the mean pressure gradient is less than 20 mmHg. Applicants with an aortic valve orifice of more than 1 $cm^2$ and a mean pressure gradient above 20 mmHg, but not greater than 50 mmHg, may be assessed as fit with an ORL or OSL. Follow-up with 2D Doppler echocardiography, as necessary, should be determined in consultation with the medical assessor of the licensing authority in all cases. Alternative measurement techniques with equivalent ranges may be used. Regular cardiological evaluation should be considered. Applicants with a history of systemic embolism or significant dilatation of the thoracic aorta should be assessed as unfit.

(iii) Applicants with trivial aortic regurgitation may be assessed as fit. Applicants with a greater degree of aortic regurgitation may be assessed as fit with an OSL. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Follow-up, as necessary, should be determined in consultation with the medical assessor of the licensing authority.

(4) Mitral valve disease

(i) Asymptomatic applicants with an isolated mid-systolic click due to mitral leaflet prolapse may be assessed as fit.

(ii) Applicants with rheumatic mitral stenosis should be assessed as unfit.

(iii) Applicants with minor regurgitation may be assessed as fit. Periodic cardiological review should be determined in consultation with the medical assessor of the licensing authority.

(iv) Applicants with moderate mitral regurgitation may be considered as fit with an ORL or OSL if the 2D Doppler echocardiogram demonstrates satisfactory left ventricular dimensions and satisfactory myocardial function is confirmed by exercise electrocardiography. Periodic cardiological review should be determined in consultation with the medical assessor of the licensing authority.

(v) Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter or evidence of systolic impairment should be assessed as unfit.

(f) Valvular surgery

(1) Applicants who have undergone cardiac valve replacement or repair may be assessed as fit without limitations subject to satisfactory post-operative cardiological evaluation and if no anticoagulants are needed.

(2) Where anticoagulation is needed after valvular surgery, a fit assessment with an ORL or OSL may be considered after cardiological evaluation if the haemorrhagic risk is acceptable. The review should show that the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. The INR target range should be determined by the type of surgery performed. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence(s) if the INR is within the target range, may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months.

(g) Thromboembolic disorders

Applicants with arterial or venous thrombosis or pulmonary embolism should be assessed as unfit. A fit assessment with an ORL or OSL may be considered after a period of stable anticoagulation as prophylaxis in consultation with the medical assessor of the licensing authority. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range and the haemorrhagic risk is acceptable. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence(s) if the INR is within the target range may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months. Applicants with pulmonary embolism should also undergo a cardiological evaluation. Following cessation of anticoagulant therapy for any indication, applicants should undergo a re-assessment in consultation with the medical assessor of the licensing authority.

(h) Other cardiac disorders

(1) Applicants with a primary or secondary abnormality of the pericardium, myocardium or endocardium may be assessed as fit subject to satisfactory cardiological evaluation.

(2) Applicants with a congenital abnormality of the heart, including those who have undergone surgical correction, may be assessed as fit subject to satisfactory cardiological evaluation. Cardiological follow-up may be necessary and should be determined in consultation with the medical assessor of the licensing authority.

(i) Syncope

(1) In the case of a single episode of vasovagal syncope which can be explained and is compatible with flight safety, a fit assessment may be considered.

(2) Applicants with a history of recurrent vasovagal syncope should be assessed as unfit. A fit assessment may be considered after a 6-month period without recurrence, providing cardiological evaluation is satisfactory. Neurological review may be indicated.

(j) Blood pressure

(1) When the blood pressure at examination consistently exceeds 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment, the applicant should be assessed as unfit.

(2) The diagnosis of hypertension requires review of other potential vascular risk factors.

(3) Applicants with symptomatic hypotension should be assessed as unfit.

(4) Anti-hypertensive treatment should be compatible with flight safety.

(5) Following initiation of medication for the control of blood pressure, applicants should be re-assessed to verify that satisfactory control has been achieved and that the treatment is compatible with the safe exercise of the privileges of the applicable licence(s).

(k) Coronary artery disease

(1) Chest pain of uncertain cause requires full investigation.

(2) Applicants with suspected asymptomatic coronary artery disease should undergo cardiological evaluation which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(3) Applicants with evidence of exercise-induced myocardial ischaemia should be assessed as unfit.

(4) After an ischaemic cardiac event, or revascularisation, applicants without symptoms should have reduced cardiovascular risk factors to an appropriate level. Medication, when used to control angina pectoris, is not acceptable. All applicants should be on appropriate secondary prevention treatment.

(i) A coronary angiogram obtained around the time of, or during, the ischaemic myocardial event and a complete, detailed clinical report of the ischaemic event and of any operative procedures should be available to the AME.

(A) There should be no stenosis more than 50 % in any major untreated vessel, in any vein or artery graft or at the site of an angioplasty/stent, except in a vessel subtending a myocardial infarction.

(B) The whole coronary vascular tree should be assessed as satisfactory by a cardiologist and particular attention should be paid to multiple stenoses and/or multiple revascularisations.

(C) Applicants with an untreated stenosis greater than 30 % in the left main or proximal left anterior descending coronary artery should be assessed as unfit.

(ii) At least 6 months from the ischaemic myocardial event, including revascularisation, the following investigations should be completed (equivalent tests may be substituted):

(A) an exercise ECG showing neither evidence of myocardial ischaemia nor rhythm disturbance;

(B) an echocardiogram showing satisfactory left ventricular function with no important abnormality of wall motion and a satisfactory left ventricular ejection fraction of 50 % or more;

(C) in cases of angioplasty/stenting, a myocardial perfusion scan or stress echocardiogram, or equivalent test, which should show no evidence of reversible myocardial ischaemia. If there is doubt about revascularisation in myocardial infarction or bypass grafting, a perfusion scan, or equivalent test, should also be carried out;

(D) further investigations, such as a 24-hour ECG, may be necessary to assess the risk of any significant rhythm disturbance.

(iii) Periodic follow-up should include a cardiological evaluation.

(A) After coronary artery bypass grafting, a myocardial perfusion scan (or equivalent test) should be performed if there is any indication, and in all cases within five years from the procedure for a fit assessment without an OSL, OPL or ORL.

(B) In all cases, coronary angiography should be considered at any time if symptoms, signs or non-invasive tests indicate myocardial ischaemia.

(iv) Successful completion of the six-month or subsequent review will allow a fit assessment. Applicants may be assessed as fit with an ORL or OSL having successfully completed only an exercise ECG.

(5) Applicants with angina pectoris should be assessed as unfit, whether or not it is alleviated by medication.

(l) Rhythm and conduction disturbances

(1) Applicants with significant rhythm or conduction disturbance should undergo cardiological evaluation before a fit assessment may be considered with an ORL or OSL, as appropriate. Such evaluation should include:

(i) exercise ECG to the Bruce protocol or equivalent. Bruce stage 4 should be achieved and no significant abnormality of rhythm or conduction, or evidence of myocardial ischaemia should be demonstrated. Withdrawal of cardioactive medication prior to the test should normally be required;

(ii) 24-hour ambulatory ECG which should demonstrate no significant rhythm or conduction disturbance;

(iii) 2D Doppler echocardiogram which should show no significant selective chamber enlargement or significant structural or functional abnormality, and a left ventricular ejection fraction of at least 50 %.

Further evaluation may include (equivalent tests may be substituted):

(iv) 24-hour ECG recording repeated as necessary;

(v) electrophysiological study;

(vi) myocardial perfusion imaging;

(vii) cardiac magnetic resonance imaging (MRI);

(viii) coronary angiogram.

(2) Where anticoagulation is needed for a rhythm disturbance, a fit assessment with an ORL or OSL may be considered, if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence(s) if the INR is within the target range may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months.

(3) Ablation

A fit assessment may be considered following successful catheter ablation subject to satisfactory cardiological review undertaken at a minimum of 2 months after the ablation.

(4) Supraventricular arrhythmias

(i) Applicants with significant disturbance of supraventricular rhythm, including sinoatrial dysfunction, whether intermittent or established, may be assessed as fit if cardiological evaluation is satisfactory.

(ii) Applicants with atrial fibrillation/flutter may be assessed as fit if cardiological evaluation is satisfactory and the stroke risk is sufficiently low. Where anticoagulation is needed, a fit assessment with an ORL or OSL may be considered after a period of stable anticoagulation as prophylaxis, in consultation with the medical assessor of the licensing authority. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence(s) if the INR is within the target range may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months.

(iii) Applicants with asymptomatic sinus pauses up to 2.5 seconds on resting electrocardiography may be assessed as fit if cardiological evaluation is satisfactory.

(5) Heart block

(i) Applicants with first degree and Mobitz type 1 AV block may be assessed as fit.

(ii) Applicants with Mobitz type 2 AV block may be assessed as fit in the absence of distal conducting tissue disease.

(6) Complete right bundle branch block

Applicants with complete right bundle branch block may be assessed as fit with appropriate limitations, such as an ORL, and subject to satisfactory cardiological evaluation.

(7) Complete left bundle branch block

Applicants with complete left bundle branch block may be assessed as fit with appropriate limitations, such as an ORL, and subject to satisfactory cardiological evaluation.

(8) Ventricular pre-excitation

Asymptomatic applicants with ventricular pre-excitation may be assessed as fit with limitation(s) as appropriate, subject to satisfactory cardiological evaluation. Limitations may not be necessary if an electrophysiological study is conducted and the results are satisfactory.

(9) Pacemaker

Applicants with a subendocardial pacemaker should be assessed as unfit. A fit assessment may be considered no sooner than 3 months after insertion, providing:

(i) there is no other disqualifying condition;

(ii) a bipolar lead system, programmed in bipolar mode without automatic mode change, has been used;

(iii) the applicant is not pacemaker dependent; and

(iv) the applicant has a follow-up at least every 12 months, including a pacemaker check.

(10) QT prolongation

Applicants with asymptomatic QT prolongation may be assessed as fit with an ORL or OSL subject to satisfactory cardiological evaluation.

(11) Brugada pattern on electrocardiography

Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitation(s) as appropriate, subject to satisfactory cardiological evaluation.

(m) Heart or heart/lung transplantation

(1) Applicants who have undergone heart or heart/lung transplantation may be assessed as fit, with appropriate limitation(s) such as an ORL , no sooner than 12 months after transplantation, provided that cardiological evaluation is satisfactory with:

(i) no rejection in the first year following transplantation;

(ii) no significant arrhythmias;

(iii) a left ventricular ejection fraction ≥ 50%;

(iv) a symptom limited exercise ECG; and

(v) a coronary angiogram if indicated;

(2) Regular cardiological evaluations should be carried out.

## GM1 MED.B.010 Cardiovascular system

*ED Decision 2019/002/R*

**MITRAL VALVE DISEASE**

(a) Minor regurgitation should have evidence of no thickened leaflets or flail chordae and left atrial internal diameter of less than or equal to 4.0 cm.

(b) The following may indicate severe regurgitation:

(1) LV internal diameter (diastole) > 6.0 cm; or

(2) LV internal diameter (systole) > 4.1 cm; or

(3) Left atrial internal diameter > 4.5 cm.

(c) Doppler indices, such as width of jet, backwards extension and whether there is flow reversal in the pulmonary veins may be helpful in assessing severity of regurgitation.

## GM2 MED.B.010 Cardiovascular system

*ED Decision 2019/002/R*

**VENTRICULAR PRE-EXCITATION**

Asymptomatic applicants with pre-excitation may be assessed as fit if they meet the following criteria, which may also indicate a satisfactory electrophysiological evaluation:

(a) refractory period > 300 ms;

(b) no induced atrial fibrillation.

## GM3 MED.B.010 Cardiovascular system

*ED Decision 2019/002/R*

**ANTICOAGULATION**

Applicants taking anticoagulant medication which requires monitoring with INR testing, should measure their INR on a 'near patient' testing system within 12 hours prior to flight and the privileges of the applicable licence(s) should only be exercised if the INR is within the target range. The INR result should be recorded and the results should be reviewed at each aero-medical assessment.

## GM4 MED.B.010 Cardiovascular system

*ED Decision 2019/002/R*

**MITRAL VALVE DISEASE**

(a) Minor regurgitation should have evidence of no thickened leaflets or flail chordae and left atrial internal diameter of less than or equal to 4.0 cm.

(b) The following may indicate severe regurgitation:

(1) LV internal diameter (diastole) > 6.0 cm; or

(2) LV internal diameter (systole) > 4.1 cm; or

(3) Left atrial internal diameter > 4.5 cm.

(c) Doppler indices, such as width of jet, backwards extension and whether there is flow reversal in the pulmonary veins may be helpful in assessing severity of regurgitation.

## GM5 MED.B.010 Cardiovascular system

ED Decision 2019/002/R

**VENTRICULAR PRE-EXCITATION**

Asymptomatic applicants with pre-excitation may be assessed as fit if they meet the following criteria:

(a) no inducible re-entry tachycardia;

(b) refractory period > 300 ms;

(c) no induced atrial fibrillation;

(d) no evidence of multiple accessory pathways.

## MED.B.015 Respiratory System

Regulation (EU) 2024/2076

(a) Applicants with significant impairment of pulmonary function shall be assessed as unfit. However, they may be assessed as fit once pulmonary function has recovered and is satisfactory.

(b) Applicants for a class 1 medical certificate shall undertake pulmonary morphological and functional tests at the initial examination and when clinically indicated.

*[applicable until 12 February 2025 - Regulation (EU) 2019/27]*

(b) Applicants for a class 1 medical certificate shall undertake pulmonary functional tests at the initial examination and when clinically indicated.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(ba) For class 1 medical certificate holders involved in single-pilot HEMS operations, pulmonary functional tests and obstructive sleep apnoea (OSA) screening shall be completed at the first revalidation or renewal examination after the age of 60.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(c) Applicants for a class 2 medical certificate shall undertake pulmonary morphological and functional tests when clinically indicated.

*[applicable until 12 February 2025 - Regulation (EU) 2019/27]*

(c) Applicants for a class 2 medical certificate shall undertake pulmonary morphological and functional tests when clinically or epidemiologically indicated.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(d) Applicants with a medical history or diagnosis of any of the following medical conditions shall undertake respiratory evaluation with a satisfactory result before they may be assessed as fit:

(1) asthma requiring medication;

(2) active inflammatory disease of the respiratory system;

(3) active sarcoidosis;

(4) pneumothorax;

(5) sleep apnoea syndrome;

(6) major thoracic surgery;

(7) pneumonectomy;

(8) chronic obstructive pulmonary disease.

Before further consideration is given to their application, applicants with an established diagnosis of any of the medical conditions specified in points (3) and (5) shall undergo satisfactory cardiological evaluation.

(e) Aero-medical assessment

(1) Applicants for a class 1 medical certificate with any of the medical conditions specified in point (d) shall be referred to the medical assessor of the licensing authority.

(2) Applicants for a class 2 medical certificate with any of the medical conditions specified in point (d) shall be assessed in consultation with the medical assessor of the licensing authority.

(f) Applicants for a class 1 medical certificate who have undergone a pneumonectomy shall be assessed as unfit.

## AMC1 MED.B.015 Respiratory system

*ED Decision 2019/002/R*

(a) Examination

(1) Spirometry

A spirometric examination is required for initial examination and on clinical indication. Applicants with an FEV1/FVC ratio of less than 70 % should be evaluated by a specialist in respiratory disease.

(2) Chest radiography

Posterior/anterior chest radiography may be required at initial, revalidation or renewal examinations if clinically or epidemiologically indicated

(b) Chronic obstructive pulmonary disease

Applicants with chronic obstructive pulmonary disease should be assessed as unfit. Applicants with only minor impairment of pulmonary function may be assessed as fit.

(c) Asthma

Applicants with asthma requiring medication or experiencing recurrent attacks of asthma may be assessed as fit if the asthma is considered stable with satisfactory pulmonary function tests and medication is compatible with flight safety. Applicants requiring systemic steroids should be assessed as unfit.

(d) Inflammatory disease

For applicants with active inflammatory disease of the respiratory system a fit assessment may be considered when the condition has resolved without sequelae and no medication is required.

(e) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Investigation should be undertaken with respect to the possibility of systemic, particularly cardiac, involvement. A fit assessment may be considered if no medication is required, and the disease is investigated and shown to be limited to hilar lymphadenopathy and inactive.

(2) Applicants with cardiac or neurological sarcoid should be assessed as unfit.

(f) Pneumothorax

(1) Applicants with a spontaneous pneumothorax should be assessed as unfit. A fit assessment may be considered if respiratory evaluation is satisfactory:

(i) 1 year following full recovery from a single spontaneous pneumothorax;

(ii) at revalidation, 6 weeks following full recovery from a single spontaneous pneumothorax, with an OML for at least a year after full recovery;

(iii) following surgical intervention in the case of a recurrent pneumothorax provided there is satisfactory recovery.

(2) Applicants with a recurrent spontaneous pneumothorax that has not been surgically should be assessed as unfit.

(3) A fit assessment following full recovery from a traumatic pneumothorax as a result of an accident or injury may be acceptable once full absorption of the pneumothorax is demonstrated.

(g) Thoracic surgery

(1) Applicants requiring major thoracic surgery should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

(2) A fit assessment following lesser chest surgery may be considered after satisfactory recovery and full respiratory evaluation.

(h) Sleep apnoea syndrome/sleep disorder

Applicants with unsatisfactorily treated sleep apnoea syndrome should be assessed as unfit.

## AMC2 MED.B.015 Respiratory system

*ED Decision 2019/002/R*

(a) Examination

(1) A spirometric examination should be performed on clinical indication. Applicants with a forced expiratory volume in the first one second (FEV1)/forced vital capacity(FVC)ratio of less than 70 % should be evaluated by a specialist in respiratory disease.

(2) Posterior/anterior chest radiography may be required if clinically or epidemiologically indicated.

(b) Chronic obstructive pulmonary disease

Applicants with only minor impairment of pulmonary function may be assessed as fit.

(c) Asthma

Applicants with asthma may be assessed as fit if the asthma is considered stable with satisfactory pulmonary function tests and medication is compatible with flight safety. Applicants requiring systemic steroids should be assessed as unfit.

(d) Inflammatory disease

Applicants with active inflammatory disease of the respiratory system should be assessed as unfit pending resolution of the condition.

(e) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Investigation should be undertaken with respect to the possibility of systemic involvement. A fit assessment may be considered once the disease is inactive.

(2) Applicants with cardiac sarcoid should be assessed as unfit.

(f) Pneumothorax

(1) Applicants with spontaneous pneumothorax should be assessed as unfit. A fit assessment may be considered if respiratory evaluation is satisfactory:

(i) six weeks following full recovery from a single spontaneous pneumothorax;

(ii) following surgical intervention in the case of a recurrent pneumothorax, provided there is satisfactory recovery.

(2) A fit assessment following full recovery from a traumatic pneumothorax as a result of an accident or injury may be acceptable once full absorption of the pneumothorax is demonstrated.

(g) Thoracic surgery

Applicants requiring major thoracic surgery should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

(h) Sleep apnoea syndrome

Applicants with unsatisfactorily treated sleep apnoea syndrome should be assessed as unfit.

## MED.B.020 Digestive System

*Regulation (EU) 2019/27*

(a) Applicants with any sequelae of disease or surgical intervention in any part of the digestive tract or its adnexa likely to cause incapacitation in flight, in particular any obstruction due to stricture or compression, shall be assessed as unfit.

(b) Applicants who have herniae that might give rise to incapacitating symptoms shall be assessed as unfit.

(c) Applicants with any of the following disorders of the gastrointestinal system may be assessed as fit subject to satisfactory gastrointestinal evaluation after successful treatment or full recovery after surgery:

(1) recurrent dyspeptic disorder requiring medication;

(2) pancreatitis;

(3) symptomatic gallstones;

(4) a clinical diagnosis or documented medical history of chronic inflammatory bowel disease;

(5) after surgical operation on the digestive tract or its adnexa, including surgery involving total or partial excision or a diversion of any of these organs.

(d) Aero-medical assessment

(1) Applicants for a class 1 medical certificate with the diagnosis of any of the medical conditions specified in points (2), (4) and (5) of point (c) shall be referred to the medical assessor of the licensing authority.

(2) The fitness of applicants for a class 2 medical certificate with the diagnosis of the medical condition specified in point (2) of point (c) shall be assessed in consultation with the medical assessor of the licensing authority.

## AMC1 MED.B.020 Digestive system

*ED Decision 2019/002/R*

(a) Oesophageal varices

Applicants with oesophageal varices should be assessed as unfit.

(b) Pancreatitis

Applicants with pancreatitis should be assessed as unfit pending assessment. A fit assessment may be considered if the cause is removed.

(c) Gallstones

(1) Applicants with a single asymptomatic large gallstone discovered incidentally may be assessed as fit if not likely to cause incapacitation in flight.

(2) Applicants with asymptomatic multiple gallstones may be assessed as fit with an OML.

(d) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease should be assessed as fit if the inflammatory bowel disease is in established remission and stable and if systemic steroids are not required for its control.

(e) Peptic ulceration

Applicants with peptic ulceration should be assessed as unfit pending full recovery and demonstrated healing.

(f) Digestive tract and abdominal surgery

Applicants who have undergone a surgical operation for medical conditions of the digestive tract or its adnexa, including a total or partial excision or a diversion of any of these organs or herniae should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic, and there is only a minimal risk of secondary complication or recurrence.

(g) Liver disease

Applicants with morphological or functional liver disease, or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.

## AMC2 MED.B.020 Digestive system

*ED Decision 2019/002/R*

(a) Oesophageal varices

Applicants with oesophageal varices should be assessed as unfit.

(b) Pancreatitis

Applicants with pancreatitis should be assessed as unfit pending satisfactory recovery.

(c) Gallstones

(1) Applicants with a single asymptomatic large gallstone or asymptomatic multiple gallstones may be assessed as fit.

(2) Applicants with symptomatic single or multiple gallstones should be assessed as unfit. A fit assessment may be considered following gallstone removal.

(d) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease may be assessed as fit provided that the disease is stable and not likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(e) Peptic ulceration

Applicants with peptic ulceration should be assessed as unfit pending full recovery.

(f) Digestive tract and abdominal surgery

Applicants who have undergone a surgical operation:

(1) for herniae; or

(2) on the digestive tract or its adnexa, including a total or partial excision or diversion of any of these organs

should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic, and there is only a minimal risk of secondary complication or recurrence.

(g) Liver disease

Applicants with morphological or functional liver disease, or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.

## MED.B.025 Metabolic and Endocrine Systems

*Regulation (EU) 2019/27*

(a) Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit subject to demonstrated stability of the medical condition and satisfactory aero-medical evaluation.

(b) *Diabetes mellitus*

(1) Applicants with diabetes mellitus requiring insulin shall be assessed as unfit.

(2) Applicants with diabetes mellitus not requiring insulin shall be assessed as unfit unless it can be demonstrated that blood sugar control has been achieved and is stable.

(c) Aero-medical assessment

(1) Applicants for a class 1 medical certificate requiring medication other than insulin for blood sugar control shall be referred to the medical assessor of the licensing authority.

(2) The fitness of applicants for a class 2 medical certificate requiring medication other than insulin for blood sugar control shall be assessed in consultation with the medical assessor of the licensing authority.

## AMC1 MED.B.025 Metabolic and endocrine systems

*ED Decision 2019/002/R*

(a) Metabolic, nutritional or endocrine dysfunction

Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit if the condition is asymptomatic, clinically compensated and stable with or without replacement therapy, and regularly reviewed by an appropriate specialist.

(b) Obesity

Applicants with a Body Mass Index $\geq$ 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the applicable licence(s) and the results of a risk assessment, including evaluation of the cardiovascular system and evaluation of the possibility of sleep apnoea, are satisfactory.

(c) Addison's disease

Applicants with Addison's disease should be assessed as unfit. A fit assessment with an OML may be considered, provided that cortisone is carried and available for use whilst exercising the privileges of the applicable licence(s).

(d) Gout

Applicants with acute gout should be assessed as unfit. A fit assessment may be considered once asymptomatic, after cessation of treatment or the condition is stabilised on anti-hyperuricaemic therapy.

(e) Thyroid dysfunction

Applicants with hyperthyroidism or hypothyroidism should be assessed as unfit. A fit assessment may be considered when a stable euthyroid state is attained.

(f) Abnormal glucose metabolism

Glycosuria and abnormal blood glucose levels require investigation. A fit assessment may be considered if normal glucose tolerance is demonstrated (low renal threshold) or impaired glucose tolerance without diabetic pathology is fully controlled by diet and regularly reviewed.

(g) Diabetes mellitus

Subject to good control of blood sugar with no hypoglycaemic episodes:

(1) applicants with diabetes mellitus not requiring medication may be assessed as fit;

(2) the use of antidiabetic medications that are not likely to cause hypoglycaemia may be acceptable for a fit assessment with an OML.

## AMC2 MED.B.025 Metabolic and endocrine systems

*ED Decision 2019/002/R*

(a) Metabolic, nutritional or endocrine dysfunction

Applicants with metabolic, nutritional or endocrine dysfunction should be assessed as unfit. A fit assessment may be considered if the condition is asymptomatic, clinically compensated and stable.

(b) Obesity

Applicants with a Body Mass Index ≥ 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the applicable licence(s) and the results of a risk assessment, including evaluation of the cardiovascular system and evaluation of the possibility of sleep apnoea, are satisfactory.

(c) Addison's disease

Applicants with Addison's disease may be assessed as fit provided that cortisone is carried and available for use whilst exercising the privileges of the applicable licence(s).

(d) Gout

Applicants with acute gout should be assessed as unfit until asymptomatic.

(e) Thyroid dysfunction

Applicants with thyroid disease may be assessed as fit once a stable euthyroid state is attained.

(f) Abnormal glucose metabolism

Glycosuria and abnormal blood glucose levels require investigation. A fit assessment may be considered if normal glucose tolerance is demonstrated (low renal threshold) or impaired glucose tolerance is fully controlled by diet and regularly reviewed.

(g) Diabetes mellitus

Applicants with diabetes mellitus may be assessed as fit. The use of antidiabetic medications that are not likely to cause hypoglycaemia may be acceptable.

## MED.B.030 Haematology

*Regulation (EU) 2019/27*

(a) Applicants for a class 1 medical certificate shall be subjected to an haemoglobin test at each aero-medical examination.

(b) Applicants with a haematological condition may be assessed as fit subject to satisfactory aero-medical evaluation.

(c) Applicants for a class 1 medical certificate with any of the following haematological conditions shall be referred to the medical assessor of the licensing authority:

(1) abnormal haemoglobin, including, but not limited to anaemia, erythrocytosis or haemoglobinopathy;

(2) significant lymphatic enlargement;

(3) enlargement of the spleen;

(4) coagulation, haemorrhagic or thrombotic disorder;

(5) leukaemia.

(d) The fitness of applicants for a class 2 medical certificate with any of the haematological conditions specified in points (4) and (5) of point (c) shall be assessed in consultation with the medical assessor of the licensing authority.

## AMC1 MED.B.030 Haematology

*ED Decision 2019/002/R*

(a) Abnormal haemoglobin

Applicants with abnormal haemoglobin should be investigated.

(b) Anaemia

(1) Applicants with anaemia demonstrated by a reduced haemoglobin level require investigation. Applicants with an haematocrit of less than 32 % should be assessed as unfit. A fit assessment may be considered in cases where the primary cause, such as iron or B12 deficiency, has been treated and the haemoglobin or haematocrit has stabilised at a satisfactory level.

(2) Applicants with anaemia which is unamenable to treatment should be assessed as unfit.

(c) Erythrocytosis

Applicants with erythrocytosis should be assessed as unfit. A fit assessment with an OML may be considered if investigation establishes that the condition is stable and no associated pathology is demonstrated.

(d) Haemoglobinopathy

(1) Applicants with a haemoglobinopathy should be assessed as unfit. A fit assessment may be considered where minor thalassaemia or other haemoglobinopathy is diagnosed without a history of crises and where full functional capability is demonstrated. The haemoglobin level should be satisfactory.

(2) Applicants with sickle cell disease (homozygote) should be assessed as unfit.

(e) Coagulation disorders

(1) Applicants with a coagulation disorder should be assessed as unfit. A fit assessment may be considered if there is no history of significant bleeding episodes.

(2) Applicants with thrombocytopenia with a platelet count less than $75x10^9$/L should be assessed as unfit. A fit assessment may be considered once the platelet count is above $75x10^9$/L and stable.

(f) Haemorrhagic disorders

Applicants with a haemorrhagic disorder require investigation. A fit assessment with an OML may be considered if there is no history of significant bleeding.

(g) Thromboembolic disorders

(1) Applicants with a thrombotic disorder require investigation. A fit assessment may be considered when the applicant is asymptomatic and there is only minimal risk of secondary complication or recurrence.

(2) If anticoagulation is used as treatment, refer to AMC1 MED.B.010(g).

(3) Applicants with arterial embolus should be assessed as unfit. A fit assessment may be considered once recovery is complete, the applicant is asymptomatic, and there is only minimal risk of secondary complication or recurrence.

(h) Disorders of the lymphatic system

Applicants with significant localised and generalised enlargement of the lymphatic glands or haematological disease should be assessed as unfit and require investigation. A fit assessment may be considered in cases of an acute infectious process which is fully recovered or Hodgkin's lymphoma or other lymphoid malignancy which has been treated and is in full remission.

(i) Leukaemia

(1) Applicants with acute leukaemia should be assessed as unfit. Once in established remission, applicants may be assessed as fit.

(2) Applicants with chronic leukaemia should be assessed as unfit. After a period of demonstrated stability a fit assessment may be considered.

(3) Applicants with a history of leukaemia should have no history of central nervous system involvement and no continuing side-effects from treatment of flight safety importance. Haemoglobin and platelet levels should be satisfactory. Regular follow-up is required.

(j) Splenomegaly

Applicants with splenomegaly should be assessed as unfit and require investigation. A fit assessment may be considered when the enlargement is minimal, stable and no associated pathology is demonstrated, or if the enlargement is minimal and associated with another acceptable condition.

## AMC2 MED.B.030 Haematology

*ED Decision 2019/002/R*

(a) Abnormal haemoglobin

Haemoglobin should be tested when clinically indicated.

(b) Anaemia

Applicants with anaemia demonstrated by a reduced haemoglobin level or low haematocrit may be assessed as fit once the primary cause has been treated and the haemoglobin or haematocrit has stabilised at a satisfactory level.

(c) Erythrocytosis

Applicants with erythrocytosis may be assessed as fit if the condition is stable and no associated pathology is demonstrated.

(d) Haemoglobinopathy

Applicants with a haemoglobinopathy may be assessed as fit if minor thalassaemia or other haemoglobinopathy is diagnosed without a history of crises and where full functional capability is demonstrated.

(e) Coagulation and haemorrhagic disorders

Applicants with a coagulation or haemorrhagic disorder may be assessed as fit if there is no likelihood of significant bleeding.

(f) Thromboembolic disorders

Applicants with a thrombotic disorder may be assessed as fit if there is minimal likelihood of significant clotting episodes. If anticoagulation is used as treatment, refer to AMC2 MED.B.010(g).

(g) Disorders of the lymphatic system

Applicants with significant enlargement of the lymphatic glands or haematological disease may be assessed as fit if the condition is unlikely to interfere with the safe exercise of the privileges of the applicable licence(s). Applicants may be assessed as fit in cases of acute infectious process which is fully recovered or Hodgkin's lymphoma or other lymphoid malignancy which has been treated and is in full remission.

(h) Leukaemia

(1) Applicants with acute leukaemia may be assessed as fit once in established remission.

(2) Applicants with chronic leukaemia may be assessed as fit after a period of demonstrated stability.

(3) In cases (h)(1) and (h)(2), there should be no history of central nervous system involvement and no continuing side effects from treatment of flight safety importance. Haemoglobin and platelet levels should be satisfactory. Regular follow-up is required.

(i) Splenomegaly

Applicants with splenomegaly may be assessed as fit if the enlargement is minimal, stable and no associated pathology is demonstrated, or if the enlargement is minimal and associated with another acceptable condition.

## MED.B.035 Genitourinary System

*Regulation (EU) 2019/27*

(a) Urinalysis shall form part of each aero-medical examination. Applicants shall be assessed as unfit where their urine contains abnormal elements considered to be of pathological significance that could entail a degree of functional incapacity which is likely to jeopardise the safe exercise of the privileges of the license or could render the applicant likely to become suddenly unable to exercise those privileges.

(b) Applicants with any sequelae of disease or surgical procedures on the genitourinary system or its adnexa likely to cause incapacitation, in particular any obstruction due to stricture or compression, shall be assessed as unfit.

(c) Applicants with a diagnosis or medical history of the following may be assessed as fit subject to satisfactory genitourinary evaluation, as applicable:

(1) renal disease;

(2) one or more urinary calculi, or a medical history of renal colic.

(d) Applicants who have undergone a major surgical operation in the genitourinary system or its adnexa involving a total or partial excision or a diversion of their organs shall be assessed as unfit. However, after full recovery, they may be assessed as fit.

(e) The applicants for a class 1 medical certificate referred to in points (c) and (d) shall be referred to the medical assessor of the licensing authority.

# AMC1 MED.B.035 Genitourinary system

ED Decision 2019/002/R

(a) Abnormal urinalysis

Investigation is required if there is any abnormal finding on urinalysis.

(b) Renal disease

(1) Applicants presenting with any signs of renal disease should be assessed as unfit. A fit assessment may be considered if blood pressure is satisfactory and renal function is acceptable.

(2) Applicants requiring dialysis should be assessed as unfit.

(c) Urinary calculi

(1) Applicants with an asymptomatic calculus or a history of renal colic require investigation.

(2) Applicants presenting with one or more urinary calculi should be assessed as unfit and require investigation.

(3) Whilst awaiting assessment or treatment, a fit assessment with an OML may be considered.

(4) After successful treatment for a calculus a fit assessment without an OML may be considered.

(5) Applicants with parenchymal residual calculi may be considered for a fit assessment with an OML.

(d) Renal and urological surgery

(1) Applicants who have undergone a major surgical operation on the genitourinary system or its adnexa involving a total or partial excision or a diversion of any of its organs, should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

(2) After other urological surgery, a fit assessment may be considered when the applicant is completely asymptomatic and there is only minimal risk of secondary complication or recurrence.

(3) Applicants with compensated nephrectomy without hypertension or uraemia may be considered for a fit assessment.

(4) Applicants who have undergone renal transplantation may be considered for a fit assessment with an OML if it is fully compensated and tolerated with only minimal immuno-suppressive therapy after at least 12 months.

(5) Applicants who have undergone total cystectomy may be considered for a fit assessment with an OML if there is satisfactory urinary function, no infection and no recurrence of primary pathology.

## AMC2 MED.B.035 Genitourinary system

*ED Decision 2019/002/R*

(a) Renal disease

Applicants presenting with renal disease may be assessed as fit if blood pressure is satisfactory and renal function is acceptable. Applicants requiring dialysis should be assessed as unfit.

(b) Urinary calculi

(1) Applicants presenting with one or more urinary calculi should be assessed as unfit.

(2) Applicants with an asymptomatic calculus or a history of renal colic require investigation.

(3) While awaiting assessment or treatment, a fit assessment with an OSL may be considered.

(4) After successful treatment the applicant may be assessed as fit.

(5) Applicants with parenchymal residual calculi may be assessed as fit.

(c) Renal and urological surgery

(1) Applicants who have undergone a major surgical operation on the genitourinary system or its adnexa involving a total or partial excision or a diversion of any of its organs, should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

(2) After other urological surgery, a fit assessment may be considered when the applicant is completely asymptomatic and there is only minimal risk of secondary complication or recurrence.

(3) Applicants with compensated nephrectomy without hypertension or uraemia may be assessed as fit.

(4) Applicants who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and with only minimal immuno-suppressive therapy.

(5) Applicants who have undergone total cystectomy may be considered for a fit assessment if there is satisfactory urinary function, no infection and no recurrence of primary pathology.

## MED.B.040 Infectious Disease

*Regulation (EU) 2019/27*

(a) Applicants shall be assessed as unfit where they have a clinical diagnosis or medical history of any infectious disease which is likely to jeopardise the safe exercise of the privileges of the licence.

(b) Applicants who are HIV positive may be assessed as fit subject to satisfactory aero-medical evaluation. Such applicants for a class 1 medical certificate shall be referred to the medical assessor of the licensing authority.

## AMC1 MED.B.040 Infectious disease

ED Decision 2019/002/R

(a) Infectious disease General

In cases of infectious disease, consideration should be given to a history of, or clinical signs indicating, underlying impairment of the immune system.

(b) Tuberculosis

(1) Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy.

(2) Applicants with quiescent or healed lesions may be assessed as fit. Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.

(c) Syphilis

Applicants with acute syphilis should be assessed as unfit. A fit assessment may be considered in the case of those fully treated and recovered from the primary and secondary stages.

(d) HIV positivity

(1) Applicants who are HIV positive may be assessed as fit with an OML if a full investigation provides no evidence of HIV associated diseases that might give rise to incapacitating symptoms. Frequent review of the immunological status and neurological evaluation by an appropriate specialist should be carried out. A cardiological evaluation may also be required, depending on the medication.

(2) Applicants with signs or symptoms of an AIDS-defining condition should be assessed as unfit.

(e) Infectious hepatitis

Applicants with infectious hepatitis should be assessed as unfit. A fit assessment may be considered once the applicant has become asymptomatic. Regular review of the liver function should be carried out.

## AMC2 MED.B.040 Infectious disease

ED Decision 2019/002/R

(a) Tuberculosis

(1) Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy.

(2) Applicants with quiescent or healed lesions may be assessed as fit. Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.

(b) HIV positivity

(1) Applicants who are HIV positive may be assessed as fit if a full investigation provides no evidence of HIV associated diseases that might give rise to incapacitating symptoms. Frequent review of the immunological status and neurological evaluation by an appropriate specialist should be carried out. A cardiological evaluation may be required, depending on the medication.

(2) Applicants with signs or symptoms of an AIDS-defining condition should be assessed as unfit.

## MED.B.045 Obstetrics and Gynaecology

*Regulation (EU) 2019/27*

(a) Applicants who have undergone a major gynaecological operation shall be assessed as unfit. However, they may be assessed as fit after full recovery.

(b) *Pregnancy*

(1) In the event of pregnancy, an applicant may continue to exercise her privileges until the end of the 26$^{th}$ week of gestation only if the AeMC or AME considers that she is fit to do so.

(2) For holders of a class 1 medical certificate who are pregnant, an OML shall apply. Notwithstanding point MED.B.001, in that case, the OML may be imposed and removed by the AeMC or AME.

(3) An applicant may resume exercising her privileges after recovery following the end of the pregnancy.

## AMC1 MED.B.045 Obstetrics and gynaecology

*ED Decision 2019/002/R*

(a) Gynaecological surgery

Applicants who have undergone a major gynaecological operation should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic, and the risk of

(b) Pregnancy

(1) A pregnant licence holder may be assessed as fit with an OML during the first 26 weeks of gestation following review of the obstetric evaluation by the AeMC or AME who should inform the medical assessor of the licensing authority.

(2) The AeMC or AME should provide written advice to the applicant and the supervising physician regarding potentially significant complications of pregnancy.

## AMC2 MED.B.045 Obstetrics and gynaecology

*ED Decision 2019/002/R*

(a) Gynaecological surgery

Applicants who have undergone a major gynaecological operation should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication or recurrence is minimal.

(b) Pregnancy

(1) A pregnant licence holder may be assessed as fit during the first 26 weeks of gestation following satisfactory obstetric evaluation.

(2) Licence privileges may be resumed upon satisfactory confirmation of full recovery following confinement or termination of pregnancy.

## MED.B.050 Musculoskeletal System

*Regulation (EU) 2019/27*

(a) Applicants who do not have sufficient sitting height, arm and leg length and muscular strength for the safe exercise of the privileges of the licence shall be assessed as unfit. However, where their sitting height, arm and leg length and muscular strength is sufficient for the safe exercise of the privileges in respect of a certain aircraft type, which can be demonstrated where necessary through a medical flight or a simulator flight test, the applicant may be assessed as fit and their privileges shall be limited accordingly.

(b) Applicants who do not have satisfactory functional use of the musculoskeletal system to enable them to safely exercise the privileges of the licence shall be assessed as unfit. However, where their functional use of the musculoskeletal system is satisfactory for the safe exercise the privileges in respect of a certain aircraft type, which may be demonstrated where necessary through a medical flight or a simulator flight test, the applicant may be assessed as fit and their privileges shall be limited accordingly.

(c ) In case of doubt arising in the context of the assessments referred to in points (a) and (b), applicants for a class 1 medical certificate shall be referred to the medical assessor of the licensing authority and applicants for a class 2 medical certificate shall be assessed in consultation with the medical assessor of the licensing authority.

## AMC1 MED.B.050 Musculoskeletal system

*ED Decision 2019/002/R*

(a) Applicants with any significant sequelae from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery require full evaluation prior to a fit assessment.

(b) Applicants with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit, provided the condition is in remission or is stable and the applicant is taking no disqualifying medication and has satisfactorily completed a medical flight or simulator flight test. Appropriate limitation(s) apply.

(c) Applicants with abnormal musculoskeletal system, including obesity, undertaking medical fight or flight simulator testing should satisfactorily perform all tasks required for the type of flight intended, including the emergency and evacuation procedures.

## AMC2 MED.B.050 Musculoskeletal system

*ED Decision 2019/002/R*

(a) Applicants with any significant sequelae from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery should require full evaluation prior to a fit assessment.

(b) Applicants with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission or is stable and the applicant is taking no disqualifying medication and has satisfactorily completed a medical flight test. Appropriate limitation(s) may apply.

(c) Applicants with abnormal musculoskeletal system, including obesity, undertaking a medical flight test should satisfactorily perform all tasks required for the type of flight intended, including the emergency and evacuation procedures.

## MED.B.055 Mental Health

*Regulation (EU) 2019/27*

(a) Comprehensive mental health assessment shall form part of the initial class 1 aero-medical examination.

(b) Drugs and alcohol screening shall form part of the initial class 1 aero-medical examination.

(c) Applicants with a mental or behavioural disorder due to use or misuse of alcohol or other psychoactive substances shall be assessed as unfit pending recovery and freedom from psychoactive substance use or misuse and subject to satisfactory psychiatric evaluation after successful treatment.

(d) Applicants with a clinical diagnosis or documented medical history of any of the following psychiatric conditions shall undergo satisfactory psychiatric evaluation before they may be assessed as fit:

(1) mood disorder;

(2) neurotic disorder;

(3) personality disorder;

(4) mental or behavioural disorder;

(5) misuse of a psychoactive substance.

(e) Applicants with a documented medical history of a single or repeated acts of deliberate self-harm or suicide attempt shall be assessed as unfit. However, they may be assessed as fit after satisfactory psychiatric evaluation.

(f) Aero-medical assessment

(1) Applicants for a class 1 medical certificate with any of the conditions specified in point (c), (d) or (e) shall be referred to the medical assessor of the licensing authority.

(2) The fitness of applicants for a class 2 medical certificate with any of the conditions specified in point (c), (d) or (e) shall be assessed in consultation with the medical assessor of the licensing authority.

(g) Applicants with a documented medical history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder shall be assessed as unfit.

# AMC1 MED.B.055 Mental health

ED Decision 2019/002/R

(a) Mental health assessment as part of the initial class 1 aero-medical examination

(1) A comprehensive mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.

(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.

(3) The mental health assessment should include assessment and documentation of:

(i) general attitudes to mental health, including understanding possible indications of reduced mental health in themselves and others;

(ii) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;

(iii) childhood behavioural problems;

(iv) interpersonal and relationship issues;

(v) current work and life stressors; and

(vi) overt personality disorders.

(4) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(b) Mental health assessment as part of revalidation or renewal class 1 medical examination

(1) The assessment should include review and documentation of:

(i) current work and life stressors;

(ii) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;

(iii) any difficulties with operational crew resource management (CRM);

(iv) any difficulties with employer and/or other colleagues and managers; and

(v) interpersonal and relationship issues, including difficulties with relatives, friends, and work colleagues.

(2) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(3) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).

(c) Assessment of holders of a class 1 medical certificate referenced in MED.B.055(d)

Assessment of holders of a class 1 medical certificate referenced in MED.B.055(d) may require psychiatric and psychological evaluation as determined by the medical assessor of the licensing authority. A SIC limitation should be imposed in case of a fit assessment. Follow-up and removal of SIC limitation, as necessary, should be determined by the medical assessor of the licensing authority.

(d) Psychoactive substance testing

(1) Drug tests should screen for opioids, cannabinoids, amphetamines, cocaine, hallucinogens and sedative hypnotics. Following a risk assessment performed by the competent authority on the target population, screening tests may include additional drugs.

(2) For renewal/revalidation, random psychoactive substance screening test may be performed based on the risk assessment by the competent authority on the target population. If random psychoactive substance screening test is considered, it should be performed and reported in accordance with the procedures developed by the competent authority.

(3) In the case of a positive psychoactive substance screening result, confirmation should be required in accordance with national standards and procedures for psychoactive substance testing.

(4) In case of a positive confirmation test, a psychiatric evaluation should be undertaken before a fit assessment may be considered by the medical assessor of the licensing authority.

(e) Assessment and referral decisions

(1) Psychotic disorder

Applicants with a history, or the occurrence, of a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and the risk of recurrence is minimal.

(2) Organic mental disorder

Applicants with an organic mental disorder should be assessed as unfit. Once the cause has been treated, an applicant may be assessed as fit following satisfactory psychiatric evaluation.

(3) Psychoactive medication

Applicants who use psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with an OML may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed.

(4) Schizophrenia, schizotypal or delusional disorder

Applicants with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder may only be considered for a fit assessment if the medical assessor of the licensing authority concludes that the original diagnosis was inappropriate or inaccurate as confirmed by psychiatric evaluation, or, in the case of a single episode of delirium of which the cause was clear, provided that the applicant has suffered no permanent mental impairment.

(5) Mood disorder

Applicants with an established mood disorder should be assessed as unfit. After full recovery and after full consideration of the individual case, a fit assessment may be considered, depending on the characteristics and severity of the mood disorder.

(6) Neurotic, stress-related or somatoform disorder

Where there are signs or is established evidence that an applicant may have a neurotic, stress-related or somatoform disorder, the applicant should be referred for psychiatric or psychological opinion and advice.

(7) Personality or behavioural disorders

Where there are signs or is established evidence that an applicant may have a personality or behavioural disorder, the applicant should be referred for psychiatric or psychological opinion and advice.

(8) Disorders due to alcohol or other psychoactive substance(s) use or misuse

(i) Applicants with mental or behavioural disorders due to alcohol or other psychoactive substance(s) use or misuse, with or without dependency, should be assessed as unfit.

(ii) A fit assessment may be considered after a period of two years of documented sobriety or freedom from psychoactive substance use or misuse. At revalidation or renewal, a fit assessment may be considered earlier with an OML. Depending on the individual case, treatment and evaluation may include in-patient treatment of some weeks and inclusion into a support programme followed by ongoing checks, including drug and alcohol testing and reports resulting from the support programme, which may be required indefinitely.

(9) Deliberate self-harm and suicide attempt

Applicants who have carried out a single self-destructive action or repeated acts of deliberate self-harm or suicide attempt should be assessed as unfit. A fit assessment may be considered after full consideration of an individual case and may require psychiatric or psychological evaluation. Neuropsychological evaluation may also be required.

(10) Assessment

The assessment should take into consideration if the indication for the treatment, side effects and addiction risks of such treatment and the characteristics of the psychiatric disorder are compatible with flight safety.

(f) Specialist opinion and advice

(1) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC or medical assessor of the licensing authority as appropriate, detailing their opinion and recommendation.

(2) Psychiatric evaluations should be conducted by a qualified psychiatrist having adequate knowledge and experience in aviation medicine.

(3) The psychological opinion and advice should be based on a clinical psychological assessment conducted by a suitably qualified and accredited clinical psychologist with expertise and experience in aviation psychology.

(4) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and clinical interview.

## AMC2 MED.B.055 Mental health

*ED Decision 2019/002/R*

(a) Mental health assessment as part of class 2 aero-medical examination

(1) A mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.

(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.

(3) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(4) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).

(b) Assessment of holders of a class 2medical certificate referenced in MED.B.055(d)

Assessment of holders of a class 2 medical certificate referenced in MED.B.055(d) may require psychiatric and psychological evaluation as determined by the AME, AeMC or medical assessor of the licensing authority. Follow-up, as necessary, should be determined in consultation with the medical assessor of the licensing authority.

(c) Assessment and referral decisions

(1) Psychotic disorder

Applicants with a history, or the occurrence, of a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and the risk of recurrence is minimal.

(2) Organic mental disorder

Applicants with an organic mental disorder should be assessed as unfit. Once the cause has been treated, an applicant may be assessed as fit following satisfactory psychiatric evaluation.

(3) Schizophrenia, schizotypal or delusional disorder

Applicants with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder may only be considered for a fit assessment in consultation with the medical assessor of the licensing authority if the original diagnosis was inappropriate or inaccurate as confirmed by psychiatric evaluation, or, in the case of a single episode of delirium of which the cause was clear, provided that the applicant has suffered no permanent mental impairment.

(4) Mood disorder

Applicants with an established mood disorder should be assessed as unfit. After full recovery and after full consideration of the individual case, a fit assessment may be considered, depending on the characteristics and severity of the mood disorder.

(5) Neurotic, stress-related or somatoform disorder

Where there are signs or is established evidence that an applicant may have a neurotic, stress-related or somatoform disorder, the applicant should be referred for psychiatric opinion and advice.

(6) Personality or behavioural disorders

Where there are signs or is established evidence that an applicant may have a personality or behavioural disorder, the applicant should be referred for psychiatric opinion and advice.

(7) Psychoactive medication

Applicants who use psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with an OSL or OPL may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed.

(8) Disorders due to alcohol or other psychoactive substance(s) use or misuse

(i) Applicants with mental or behavioural disorders due to alcohol or other psychoactive substance(s) use or misuse, with or without dependency, should be assessed as unfit.

(ii) Drug and alcohol tests

(A) In the case of a positive drug or alcohol result, confirmation should be required in accordance with national procedures for drugs and alcohol testing.

(B) In case of a positive confirmation test, a psychiatric evaluation should be undertaken before a fit assessment may be considered.

(iii) A fit assessment may be considered after a period of two years of documented sobriety or freedom from psychoactive substance use or misuse. At revalidation or renewal, a fit assessment may be considered earlier with an OSL or OPL. Depending on the individual case, treatment and evaluation may include in-patient treatment of some weeks and inclusion into a support programme followed by ongoing checks, including drug and alcohol testing and reports resulting from the support programme, which may be required indefinitely.

(9) Deliberate self-harm

Applicants who have carried out a single self-destructive action or repeated acts of deliberate self-harm or suicide attempt should be assessed as unfit. A fit assessment may be considered after full consideration of an individual case and may require psychiatric or psychological evaluation. Neuropsychological evaluation may also be required.

(e) Specialist opinion and advice

(1) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC or medical assessor of the licensing authority as appropriate, detailing their opinion and recommendation.

(2) Psychiatric evaluations should be conducted by a qualified psychiatrist having adequate knowledge and experience in aviation medicine.

(3) The psychological opinion and advice should be based on a clinical psychological assessment conducted by a suitably qualified and accredited clinical psychologist with expertise and experience in aviation psychology.

(4) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and clinical interview.

## GM1 MED.B.055 Mental health

*ED Decision 2019/002/R*

(a) Symptoms of concern may include but are not limited to:

(1) use of alcohol or other psychoactive substances;

(2) loss of interest/energy;

(3) eating and weight changes;

(4) sleeping problems;

(5) low mood and, if present, any suicidal thoughts;

(6) family history of psychiatric disorders, particularly suicide;

(7) anger, agitation or high mood; and

(8) depersonalisation or loss of control.

(b) The following aspects should be taken into consideration when conducting the mental health examination:

(1) Appearance;

(2) Attitude;

(3) Behaviour;

(4) Mood;

(5) Speech;

(6) Thoughts process and content;

(7) Perception;

(8) Cognition;

(9) Insight; and

(10) Judgement.

## GM2 MED.B.055 Mental health

*ED Decision 2019/002/R*

(a) Drugs and alcohol screening tests used should:

(1) provide information regarding medium-term consumption;

(2) be accepted on national level by the competent authority based on the availability and suitability for the scope mentioned in point(a)(1) above.

(b) Statistical data of the screening campaign mentioned in AMC1 MED.B.055(d)(1) should be made available to the Agency on a yearly basis.

## GM3 MED.B.055 Mental health

*ED Decision 2019/002/R*

(a) The mental health assessment for class 2 applicants should include assessment and documentation of:

(1) general attitudes to mental health, including understanding possible indications of reduced mental health in themselves and others;

(2) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;

(3) childhood behavioural problems;

(4) interpersonal and relationship issues, including difficulties with relatives, friends, and work colleagues;

(5) current work and life stressors, including difficulties with aviation operational environment; and

(6) overt personality disorders.

(b) In regard to symptoms of concern and aspects to be taken into consideration when conducting mental health examination for class 2 applicants, guidance presented in GM1 MED.B.055 should be used.

## GM4 MED.B.055 Mental health

*ED Decision 2019/002/R*

Drugs and alcohol screening tests used should:

(a) provide information regarding medium-term consumption;

(b) be accepted on national level by the competent authority based on the availability and suitability with the scope mentioned in GM2 MED.B.055(a) above.

# MED.B.065 Neurology

*Regulation (EU) 2019/27*

(a) Applicants with clinical diagnosis or a documented medical history of any of the following medical conditions shall be assessed as unfit:

(1) epilepsy, except in the cases referred to in points (1) and (2) of point (b);

(2) recurring episodes of disturbance of consciousness of uncertain cause.

(b) Applicants with clinical diagnosis or a documented medical history of any of the following medical conditions shall undergo further evaluation before they may be assessed as fit:

(1) epilepsy without recurrence after age 5;

(2) epilepsy without recurrence and off all treatment for more than 10 years;

(3) epileptiform EEG abnormalities and focal slow waves;

(4) progressive or non-progressive disease of the nervous system;

(5) inflammatory disease of the central or peripheral nervous system;

(6) migraine;

(7) a single episode of disturbance of consciousness of uncertain cause;

(8) loss of consciousness after head injury;

(9) penetrating brain injury;

(10) spinal or peripheral nerve injury;

(11) disorders of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events.

Applicants for a class 1 medical certificate shall be referred to the medical assessor of the licensing authority. The fitness of applicants for a class 2 medical certificate shall be assessed in consultation with the medical assessor of the licensing authority.

# AMC1 MED.B.065 Neurology

*ED Decision 2019/002/R*

(a) Epilepsy

(1) Applicants with a diagnosis of epilepsy should be assessed as unfit unless there is unequivocal evidence of a syndrome of benign childhood epilepsy associated with a very low risk of recurrence, and unless the applicant has been free of recurrence and off treatment for more than 10 years. One or more convulsive episode after the age of 5 should lead to unfitness. In the case of an acute symptomatic seizure, which is considered to have a very low risk of recurrence, a fit assessment may be considered after neurological evaluation.

(2) Applicants may be assessed as fit with an OML if:

(i) there is a history of a single afebrile epileptiform seizure;

(ii) there has been no recurrence after at least 10 years off treatment;

(iii) there is no evidence of continuing predisposition to epilepsy.

(b) EEG

(1) Electroencephalography is required when indicated by the applicant's history or on clinical grounds.

(2) Applicants with epileptiform paroxysmal EEG abnormalities and focal slow waves should be assessed as unfit.

(c) Neurological disease

Applicants with any disease of the nervous system which is likely to cause a hazard to flight safety should be assessed as unfit. However, in certain cases, including cases of minor functional losses associated withstable disease, a fit assessment may be considered after full evaluation which should include a medical flight test which may be conducted in a flight simulation training device.

(d) Migraine

Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, therapy. Appropriate limitation(s) may apply.

(e) Episode of disturbance of consciousness

In the case of a single episode of disturbance of consciousness, which can be satisfactorily explained, a fit assessment may be considered, but applicants experiencing a recurrence should be assessed as unfit.

(f) Head injury

Applicants with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury should be evaluated by a neurologist. A fit assessment may be considered if there has been a full recovery and the risk of epilepsy is sufficiently low.

(g) Spinal or peripheral nerve injury

Applicants with a history or diagnosis of spinal or peripheral nerve injury or a disorder of the nervous system due to a traumatic injury should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC1 MED.B.050 are satisfied.

(h) Vascular deficiencies

Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC1 MED.B.050 are satisfied. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.

# AMC2 MED.B.065 Neurology

ED Decision 2019/002/R

(a) Epilepsy

Applicants may be assessed as fit if:

(1) there is a history of a single afebrile epileptiform seizure, considered to have a very low risk of recurrence;

(2) there has been no recurrence after at least 10 years off treatment; and

(3) there is no evidence of continuing predisposition to epilepsy.

(b) Neurological disease

Applicants with any disease of the nervous system which is likely to cause a hazard to flight safety should be assessed as unfit. However, in certain cases, including cases of functional loss associated with stable disease, a fit assessment may be considered after full evaluation which should include a medical flight test which may be conducted in a flight simulation training device.

(c) Migraine

Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, and therapy. Appropriate limitation(s) may apply.

(d) Head injury

Applicants with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury may be assessed as fit if there has been a full recovery and the risk of epilepsy is sufficiently low. An evaluation by a neurologist may be required depending on the staging of the original injury.

(e) Spinal or peripheral nerve injury

Applicants with a history or diagnosis of spinal or peripheral nerve injury or a disorder of the nervous system due to a traumatic injury should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC2 MED.B.050 are satisfied.

(f) Vascular deficiencies

Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the provisions of AMC2 MED.B.050 are met. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.

# MED.B.070 Visual System

*Regulation (EU) 2024/2076*

(a) Examination

(1) For a class 1 medical certificate:

(i) a comprehensive eye examination shall form part of the initial examination and shall be undertaken when clinically indicated and periodically, depending on the refraction and the functional performance of the eye.

(ii) a routine eye examination shall form part of all revalidation and renewal examinations.

(iii) when holders are involved in single-pilot HEMS operations, a comprehensive eye examination shall be completed at the first revalidation or renewal examination after the age of 60 and every year thereafter.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(2) For a class 2 medical certificate:

(i) a routine eye examination shall form part of the initial and all revalidation and renewal examinations.

(ii) a comprehensive eye examination shall be undertaken when clinically indicated.

(b) Visual acuity

(1) For a class 1 medical certificate:

(i) Distant visual acuity, with or without correction, shall be 6/9 (0,7) or better in each eye separately and visual acuity with both eyes shall be 6/6 (1,0) or better.

(ii) At the initial examination, applicants with substandard vision in one eye shall be assessed as unfit.

(iii) At revalidation and renewal examinations, notwithstanding point (b)(1)(i), applicants with acquired substandard vision in one eye or acquired monocularity shall be referred to the medical assessor of the licensing authority and may be assessed as fit subject to a satisfactory ophthalmological evaluation.

(2) For a class 2 medical certificate:

(i) Distant visual acuity, with or without correction, shall be 6/12 (0,5) or better in each eye separately and visual acuity with both eyes shall be 6/9 (0,7) or better.

(ii) Notwithstanding point (b)(2)(i), applicants with substandard vision in one eye or monocularity may be assessed as fit, in consultation with the medical assessor of the licensing authority and subject to a satisfactory ophthalmological evaluation.

(3) Applicants shall be able to read an N5 chart or equivalent at 30-50 cm and an N14 chart or equivalent at 100 cm, if necessary with correction.

(c) Refractive error and anisometropia

(1) Applicants with refractive errors or anisometropia may be assessed as fit subject to satisfactory ophthalmic evaluation.

(2) Notwithstanding point (c)(1), applicants for a class 1 medical certificate with any of the following medical conditions shall be referred to the medical assessor of the licensing

authority and may be assessed as fit subject to a satisfactory ophthalmological evaluation:

(i) myopia exceeding –6.0 dioptres;

(ii) astigmatism exceeding 2.0 dioptres;

(iii) anisometropia exceeding 2.0 dioptres.

(3) Notwithstanding point (c)(1), applicants for a class 1 medical certificate with hypermetropia exceeding +5.0 dioptres shall be referred to the medical assessor of the licensing authority and may be assessed as fit subject to a satisfactory ophthalmological evaluation, provided that there are adequate fusional reserves, normal intraocular pressures and anterior angles and no significant pathology has been demonstrated. Notwithstanding point (b)(1)(i), corrected visual acuity in each eye shall be 6/6 or better.

(4) Applicants with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist. Such applicants for a class 1 medical certificate shall be referred to the medical assessor of the licensing authority.

(d) Binocular function

(1) Applicants for a class 1 medical certificate shall be assessed as unfit, where they do not have normal binocular function and that medical condition is likely to jeopardise the safe exercise of the privileges of the license, taking account of any appropriate corrective measures where relevant.

(2) Applicants with diplopia shall be assessed as unfit.

(e) Visual fields

Applicants for a class 1 medical certificate shall be assessed as unfit, where they do not have normal fields of vision and that medical condition is likely to jeopardise the safe exercise of the privileges of the license, taking account of any appropriate corrective measures where relevant.

(f) Eye surgery

Applicants who have undergone eye surgery shall be assessed as unfit. However, they may be assessed as fit after full recovery of their visual function and subject to satisfactory ophthalmological evaluation.

(g) Spectacles and contact lenses

(1) If satisfactory visual function is achieved only with the use of correction, the spectacles or contact lenses shall provide optimal visual function, be well-tolerated and suitable for aviation purposes.

(2) No more than one pair of spectacles shall be used to meet the visual requirements when exercising the privileges of the applicable licence(s).

(3) For distant vision, spectacles or contact lenses shall be worn when exercising the privileges of the applicable licence(s).

(4) For near vision, a pair of spectacles shall be kept available when exercising the privileges of the applicable licence(s).

(5) A spare set of similarly correcting spectacles, for distant or near vision as applicable, shall be readily available for immediate use when exercising the privileges of the applicable licence(s).

(6) If contact lenses are worn when exercising the privileges of the applicable licence(s), they shall be for distant vision, monofocal, and non-tinted and well-tolerated.

(7) Applicants with a large refractive error shall use contact lenses or high-index spectacle lenses.

(8) Orthokeratological lenses shall not be used.

## AMC1 MED.B.070 Visual system

*ED Decision 2019/002/R*

(a) Eye examination

(1) At each aero-medical examination, an assessment of the visual fitness should be undertaken and the eyes should be examined with regard to possible pathology.

(2) All abnormal and doubtful cases should be referred to an ophthalmologist. Conditions which indicate ophthalmological examination include but are not limited to a substantial decrease in the uncorrected visual acuity, any decrease in best corrected visual acuity and/or the occurrence of eye disease, eye injury, or eye surgery.

(3) Where specialist ophthalmological examinations are required for any significant reason, this should be imposed as a limitation on the medical certificate.

(4) The possible cumulative effect of more than one eye condition should be evaluated by an ophthalmologist.

(b) Comprehensive eye examination

A comprehensive eye examination by an eye specialist is required at the initial examination. All abnormal and doubtful cases should be referred to an ophthalmologist. The examination should include:

(1) history;

(2) visual acuities near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(3) examination of the external eye, anatomy, media (slit lamp) and fundoscopy;

(4) ocular motility;

(5) binocular vision;

(6) visual fields;

(7) tonometry on clinical indication;

(8) objective refraction: hyperopic initial applicants with a hyperopia of more than +2 dioptres and under the age of 25 should undergo objective refraction in cycloplegia;

(9) assessment of mesopic contrast sensitivity; and

(10) colour vision.

(c) Routine eye examination

A routine eye examination may be performed by an AME and should include:

(1) history;

(2) visual acuities - near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(3) examination of the external eye, anatomy, media and fundoscopy; and

(4) further examination on clinical indication.

(d) Refractive error and anisometropia

(1) Applicants with the following conditions may be assessed as fit subject to satisfactory ophthalmic evaluation and provided that optimal correction has been considered and no significant pathology is demonstrated:

(i) hypermetropia not exceeding +5.0 dioptres;

(ii) myopia not exceeding –6.0 dioptres;

(iii) astigmatism not exceeding 2.0 dioptres;

(iv) anisometropia not exceeding 2.0 dioptres.

(2) Applicants should wear contact lenses if:

(i) hypermetropia exceeds +5.0 dioptres;

(ii) anisometropia exceeds 3.0 dioptres.

(3) An evaluation by an eye specialist should be undertaken 5-yearly if:

(i) the refractive error is between –3.0 and –6.0 dioptres or +3 and +5 dioptres;

(ii) astigmatism or anisometropia is between 2.0 and 3.0 dioptres.

(4) An evaluation by an eye specialist should be undertaken 2-yearly if:

(i) the refractive error is greater than –6.0 dioptres or +5.0 dioptres;

(ii) astigmatism or anisometropia exceeds 3.0 dioptres.

(e) Uncorrected visual acuity

No limits apply to uncorrected visual acuity.

(f) Visual acuity

(1) Reduced vision in one eye or monocularity: Applicants for revalidation or renewal with reduced central vision or acquired loss of vision in one eye may be assessed as fit with an OML if:

(i) the binocular visual field or, in the case of monocularity, the monocular visual field is acceptable;

(ii) in the case of monocularity, a period of adaptation time has passed from the known point of visual loss, during which the applicant should be assessed as unfit;

(iii) the unaffected eye achieves distant visual acuity of 6/6 (1,0) corrected or uncorrected;

(iv) the unaffected eye achieves intermediate visual acuity of N14 and N5 for near;

(v) the underlying pathology is acceptable according to ophthalmological assessment and there is no significant ocular pathology in the unaffected eye; and

(vi) a medical flight test is satisfactory.

(2) Visual fields

Applicants with a visual field defect, who do not have reduced central vision or acquired loss of vision in one eye, may be assessed as fit if the binocular visual field is normal.

(g) Keratoconus

Applicants with keratoconus may be assessed as fit if the visual requirements are met with the use of corrective lenses and periodic evaluation is undertaken by an ophthalmologist.

(h) Binocular function

Applicants with heterophoria (imbalance of the ocular muscles) exceeding:

(1) at 6 metres:

2.0 prism dioptres in hyperphoria,

10.0 prism dioptres in esophoria,

8.0 prism dioptres in exophoria

and

(2) at 33 centimetres:

1.0 prism dioptre in hyperphoria,

8.0 prism dioptres in esophoria,

12.0 prism dioptres in exophoria

should be assessed as unfit. A fit assessment may be considered if an orthoptic evaluation demonstrates that the fusional reserves are sufficient to prevent asthenopia and diplopia.

(i) Eye surgery

The assessment after eye surgery should include an ophthalmological examination.

(1) After refractive surgery, a fit assessment may be considered, provided that:

(i) stability of refraction of less than 0.75 dioptres variation diurnally has been achieved;

(ii) examination of the eye shows no post-operative complications;

(iii) glare sensitivity is within normal standards;

(iv) mesopic contrast sensitivity is not impaired;

(v) an evaluation is undertaken by an eye specialist.

(2) Following intraocular lens surgery, including cataract surgery, a fit assessment may be considered once recovery is complete and the visual requirements are met with or without correction. Intraocular lenses should be monofocal and should not impair colour vision and night vision.

(3) Retinal surgery entails unfitness. A fit assessment may be considered 6 months after surgery, or earlier if recovery is complete. A fit assessment may also be considered earlier after retinal laser therapy. Regular follow-up by an ophthalmologist should be carried out.

(4) Glaucoma surgery entails unfitness. A fit assessment may be considered 6 months after surgery or earlier if recovery is complete. Regular follow-up by an ophthalmologist should be carried out.

(j) Visual correction

Correcting lenses should permit the licence holder to meet the visual requirements at all distances.

## AMC2 MED.B.070 Visual system

*ED Decision 2019/002/R*

(a) Eye examination

(1) At each aero-medical revalidation examination an assessment of the visual fitness of the applicant should be undertaken and the eyes should be examined with regard to possible pathology. Conditions which indicate further ophthalmological examination include but are not limited to a substantial decrease in the uncorrected visual acuity, any decrease in best corrected visual acuity and/or the occurrence of eye disease, eye injury, or eye surgery.

(2) At the initial assessment, the examination should include:

(i) history;

(ii) visual acuities near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(iii) examination of the external eye, anatomy, media and fundoscopy;

(iv) ocular motility;

(v) binocular vision;

(vi) visual fields;

(vii) colour vision;

(viii) further examination on clinical indication.

(3) At the initial assessment the applicant should submit a copy of the recent spectacle prescription if visual correction is required to meet the visual requirements.

(b) Routine eye examination

A routine eye examination should include:

(1) history;

(2) visual acuities - near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(3) examination of the external eye, anatomy, media and fundoscopy;

(4) further examination on clinical indication.

(c) Visual acuity

Reduced vision in one eye or monocularity: Applicants with reduced vision or loss of vision in one eye may be assessed as fit if:

(1) the binocular visual field or, in the case of monocularity, the monocular visual field is acceptable;

(2) in the case of monocularity, a period of adaptation time has passed from the known point of visual loss, during which the applicant should be assessed as unfit;

(3) the unaffected eye achieves distant visual acuity of 6/6 (1,0), corrected or uncorrected;

(4) the unaffected eye achieves intermediate visual acuity of N14 or equivalent and N5 or equivalent for near (Refer to GM1 MED.B.070);

(5) there is no significant ocular pathology in the unaffected eye; and

(6) a medical flight test is satisfactory.

(d) Binocular function

Reduced stereopsis, abnormal convergence not interfering with near vision and ocular misalignment where the fusional reserves are sufficient to prevent asthenopia and diplopia may be acceptable.

(e) Eye surgery

(1) The assessment after eye surgery should include an ophthalmological examination.

(2) After refractive surgery a fit assessment may be considered provided that there is satisfactory stability of refraction, there are no post-operative complications and no increase in glare sensitivity.

(3) After cataract, retinal or glaucoma surgery a fit assessment may be considered once recovery is complete and the visual requirements are met with or without correction.

(f) Visual correction

Correcting lenses should permit the licence holder to meet the visual requirements at all distances.

## GM1 MED.B.070 Visual system

*ED Decision 2019/002/R*

**COMPARISON OF DIFFERENT READING CHARTS (APPROXIMATE FIGURES)**

(a) Test distance: 40 cm

| Decimal | Nieden | Jäger | Snellen | N | Parinaud |
|---|---|---|---|---|---|
| 1,0 | 1 | 2 | 1,5 | 3 | 2 |
| 0,8 | 2 | 3 | 2 | 4 | 3 |
| 0,7 | 3 | 4 | 2,5 | | |
| 0,6 | 4 | 5 | 3 | 5 | 4 |
| 0,5 | 5 | 5 | | 6 | 5 |
| 0,4 | 7 | 9 | 4 | 8 | 6 |
| 0,35 | 8 | 10 | 4,5 | | 8 |
| 0,32 | 9 | 12 | 5,5 | 10 | 10 |
| 0,3 | 9 | 12 | | 12 | |

| | | | | | |
|---|---|---|---|---|---|
| 0,25 | 9 | 12 | | 14 | |
| 0,2 | 10 | 14 | 7,5 | 16 | 14 |
| 0,16 | 11 | 14 | 12 | 20 | |

(b) Test distance: 80 cm

| Decimal | Nieden | Jäger | Snellen | N | Parinaud |
|---|---|---|---|---|---|
| 1,2 | 4 | 5 | 3 | 5 | 4 |
| 1,0 | 5 | 5 | | 6 | 5 |
| 0,8 | 7 | 9 | 4 | 8 | 6 |
| 0,7 | 8 | 10 | 4,5 | | 8 |
| 0,63 | 9 | 12 | 5,5 | 10 | 10 |
| 0,6 | 9 | 12 | | 12 | 10 |
| 0,5 | 9 | 12 | | 14 | 10 |
| 0,4 | 10 | 14 | 7,5 | 16 | 14 |
| 0,32 | 11 | 14 | 12 | 20 | 14 |

## GM2 MED.B.070 Visual system

*ED Decision 2019/002/R*

**EYE SPECIALIST**

The term 'eye specialist' refers to an ophthalmologist or a vision care specialist qualified in optometry and trained to recognise pathological conditions.

## MED.B.075 Colour vision

*Regulation (EU) 2024/2076*

(a) Applicants shall be assessed as unfit, where they cannot demonstrate their ability to readily perceive the colours that are necessary for the safe exercise of the privileges of the licence.

(b) *Examination and assessment*

(1) Applicants shall be subjected to the Ishihara test for the initial issue of a medical certificate. Applicants who pass that test may be assessed as fit.

*[applicable until 12 February 2025 - Regulation (EU)* 2019/27*]*

(1) Applicants shall be subjected to the Ishihara test for the initial issue of a medical certificate. For class 1 medical certificate holders involved in single-pilot HEMS operations, a colour vision assessment shall be completed at the first revalidation or renewal examination after the age of 60 and every year thereafter. Applicants who pass that test may be assessed as fit.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(2) For a class 1 medical certificate:

(i) Applicants who do not pass the Ishihara test shall be referred to the medical assessor of the licensing authority and shall undergo further colour perception testing to establish whether they are colour safe.

(ii) Applicants shall be normal trichromats or shall be colour safe.

(iii) Applicants who fail further colour perception testing shall be assessed as unfit.

(3) For a class 2 medical certificate:

(i) Applicants who do not pass the Ishihara test shall undergo further colour perception testing to establish whether they are colour safe.

(ii) Applicants who do not have satisfactory perception of colours shall be limited to exercising the privileges of the applicable licence in daytime only.

## AMC1 MED.B.075 Colour vision

*ED Decision 2019/002/R*

(a) At revalidation and renewal examinations, colour vision should be tested on clinical indication.

(b) The Ishihara test (24 plate version) is considered passed if the first 15 plates, presented in a random order, are identified without error.

(c) Those failing the Ishihara test should be examined either by:

(1) anomaloscopy (Nagel or equivalent). This test is considered passed if the colour match is trichromatic and the matching range is 4 scale units or less, or if the anomalous quotient is acceptable; or by

(2) lantern testing with a Spectrolux, Beynes or Holmes-Wright lantern. This test is considered passed if the applicant passes without error a test with accepted lanterns.

(3) Colour Assessment and Diagnosis (CAD) test. This test is considered passed if the threshold is less than 6 standard normal (SN) units for deutan deficiency, or less than 12 SN units for protan deficiency. A threshold greater than 2 SN units for tritan deficiency indicates an acquired cause which should be investigated.

## AMC2 MED.B.075 Colour vision

*ED Decision 2019/002/R*

(a) Colour vision should be tested on clinical indication at revalidation and renewal examinations.

(b) The Ishihara test (24 plate version) is considered passed if the first 15 plates, presented in a random order, are identified without error.

(c) Those failing the Ishihara test should be examined either by:

(1) anomaloscopy (Nagel or equivalent). This test is considered passed if the colour match is trichromatic and the matching range is 4 scale units or less, or if the anomalous quotient is acceptable; or by

(2) lantern testing with a Spectrolux, Beynes or Holmes-Wright lantern. This test is considered passed if the applicant passes without error a test with accepted lanterns.

(3) Colour Assessment and Diagnosis (CAD) test. This test is considered passed if the threshold is less than 6 standard normal (SN) units for deutan deficiency, or less than 12 SN units for protan deficiency. A threshold greater than 2 SN units for tritan deficiency indicates an acquired cause which should be investigated.

# MED.B.080 Otorhinolaryngology (ENT)

Regulation (EU) 2024/2076

*(a) Examination*

(1) Applicants' hearing shall be tested at all examinations.

(i) For a class 1 medical certificate, and for a class 2 medical certificate when an instrument rating or en route instrument rating is to be added to the licence, hearing shall be tested with pure-tone audiometry at the initial examination, then every 5 years until the licence holder reaches the age of 40 and then every 2 years thereafter.

*[applicable until 12 February 2025 - Regulation (EU) 2019/27]*

(i) For a class 1 medical certificate, and for a class 2 medical certificate when an instrument rating or a basic instrument rating is to be added to the licence, hearing shall be tested with pure-tone audiometry at the initial examination, then every 5 years until the licence holder reaches the age of 40, and then every 2 years until the licence holder reaches the age of 60 and every year thereafter.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(ii) When tested on a pure-tone audiometer, initial applicants shall not have a hearing loss of more than 35 dB at any of the frequencies 500, 1 000 or 2 000 Hz, or more than 50 dB at 3 000 Hz, in either ear separately. Applicants for revalidation or renewal with greater hearing loss shall demonstrate satisfactory functional hearing ability.

(2) A comprehensive ear, nose and throat examination shall be undertaken for the initial issue of a class 1 medical certificate and periodically thereafter when clinically indicated.

(3) For class 1 medical certificate holders involved in single-pilot HEMS operations, a comprehensive ear, nose and throat examination shall be completed at the first revalidation or renewal examination after the age of 60.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(b) Applicants with any of the following medical conditions shall undergo further examination to establish that the medical condition does not interfere with the safe exercise of the privileges of the applicable licence(s):

(1) hypoacusis;

(2) an active pathological process of the internal or middle ear;

(3) unhealed perforation or dysfunction of the tympanic membrane(s);

(4) dysfunction of the Eustachian tube(s);

(5) disturbance of vestibular function;

(6) significant restriction of the nasal passages;

(7) sinus dysfunction;

(8) significant malformation or significant infection of the oral cavity or upper respiratory tract;

(9) significant disorder of speech or voice;

(10) any sequelae of surgery of the internal or middle ear.

(c) Aero-medical assessment

(1) Applicants for a class 1 medical certificate with any of the medical conditions specified in points (1), (4) and (5) of point (b) shall be referred to the medical assessor of the licensing authority.

(2) The fitness of applicants for a class 2 medical certificate with any of the medical conditions specified in point (4) and (5) of point (b) shall be assessed in consultation with the medical assessor of the licensing authority.

(3) The fitness of applicants for a class 2 medical certificate for an instrument rating or en route instrument rating to be added to the licence with the medical condition specified in point (1) of point (b) shall be assessed in consultation with the medical assessor of the licensing authority.

## AMC1 MED.B.080 Otorhinolaryngology (ENT)

*ED Decision 2019/002/R*

(a) Hearing

(1) Applicants should understand correctly conversational speech when tested with each ear at a distance of 2 metres from and with the applicant's back turned towards the AME.

(2) Applicants with hypoacusis may be assessed as fit if a speech discrimination test or functional flight deck hearing test demonstrates satisfactory hearing ability. A vestibular function test may be appropriate.

(3) If the hearing requirements can only be met with the use of hearing aids, the hearing aids should provide optimal hearing function, be well tolerated and suitable for aviation purposes.

(b) Comprehensive ENT examination

A comprehensive ENT examination should include:

(1) history;

(2) clinical examination including otoscopy, rhinoscopy, and examination of the mouth and throat;

(3) tympanometry or equivalent;

(4) clinical examination of the vestibular system.

(c) Ear conditions

(1) Applicants with an active pathological process of the internal or middle ear should be assessed as unfit. A fit assessment may be considered once the condition has stabilised or there has been a full recovery.

(2) Applicants with an unhealed perforation or dysfunction of the tympanic membranes should be assessed as unfit. An applicant with a single dry perforation of non-infectious origin and which does not interfere with the normal function of the ear may be considered for a fit assessment.

(d) Vestibular disturbance

Applicants with disturbance of vestibular function should be assessed as unfit. A fit assessment may be considered after full recovery. The presence of spontaneous or positional nystagmus requires complete vestibular evaluation by specialist. Applicants with significant abnormal caloric or rotational vestibular responses should be assessed as unfit. Abnormal vestibular responses should be assessed in their clinical context.

(e) Sinus dysfunction

Applicants with any dysfunction of the sinuses should be assessed as unfit until there has been full recovery.

(f) Oral/upper respiratory tract infections

Applicants with a significant infection of the oral cavity or upper respiratory tract should be assessed as unfit. A fit assessment may be considered after full recovery.

(g) Speech disorder

Applicants with a significant disorder of speech or voice should be assessed as unfit.

(h) Air passage restrictions

Applicants with significant restriction of the nasal air passage on either side, or significant malformation of the oral cavity or upper respiratory tract may be assessed as fit if ENT evaluation is satisfactory.

(i) Eustachian tube(s)

Applicants with permanent dysfunction of the Eustachian tube(s) may be assessed as fit if ENT evaluation is satisfactory.

(j) Sequelae of surgery of the internal or middle ear

Applicants with sequelae of surgery of the internal or middle ear should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

## AMC2 MED.B.080 Otorhinolaryngology (ENT)

*ED Decision 2019/002/R*

(a) Hearing

(1) Applicants should understand correctly conversational speech when tested with each ear at a distance of 2 metres from and with the applicant's back turned towards the AME.

(2) Applicants with hypoacusis may be assessed as fit if a speech discrimination test or functional cockpit hearing test demonstrates satisfactory hearing ability.

(3) If the hearing requirements can be met only with the use of hearing aids, the hearing aids should provide optimal hearing function, be well tolerated and suitable for aviation purposes.

(4) Applicants with profound deafness or major disorder of speech, or both, may be assessed as fit with an SSL, such as 'limited to areas and operations where the use of radio is not mandatory'. The aircraft should be equipped with appropriate alternative warning devices in lieu of sound warnings.

(b) Examination

An ENT examination should form part of all initial, revalidation and renewal examinations.

(c) Ear conditions

(1) Applicants with an active pathological process of the internal or middle ear should be assessed as unfit until the condition has stabilised or there has been a full recovery.

(2) Applicants with an unhealed perforation or dysfunction of the tympanic membranes should be assessed as unfit. An applicant with a single dry perforation of non-infectious origin which does not interfere with the normal function of the ear may be considered for a fit assessment.

(d) Vestibular disturbance

Applicants with disturbance of vestibular function should be assessed as unfit pending full recovery.

(e) Sinus dysfunction

Applicants with any dysfunction of the sinuses should be assessed as unfit pending full recovery.

(f) Oral/upper respiratory tract infections

Applicants with a significant infection of the oral cavity or upper respiratory tract should be assessed as unfit. A fit assessment may be considered after full recovery.

(g) Speech disorder

Applicants with a significant disorder of speech or voice should be assessed as unfit.

(h) Air passage restrictions

Applicants with significant restriction of the nasal air passage on either side, or significant malformation of the oral cavity or upper respiratory tract may be assessed as fit if ENT evaluation is satisfactory.

(i) Eustachian tube dysfunction

Applicants with permanent dysfunction of the Eustachian tube(s) may be assessed as fit if ENT evaluation is satisfactory.

(j) Sequelae of surgery of the internal or middle ear

Applicants with sequelae of surgery of the internal or middle ear should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

## GM1 MED.B.080 Otorhinolaryngology (ENT)

*ED Decision 2019/002/R*

**PURE TONE AUDIOGRAM**

The pure tone audiogram may also cover the 4 000 Hz frequency for early detection of decrease in hearing.

## GM2 MED.B.080 Otorhinolaryngology (ENT)

*ED Decision 2019/002/R*

**PURE TONE AUDIOGRAM**

The pure tone audiogram may also cover the 4 000 Hz frequency for early detection of decrease in hearing.

## MED.B.085 Dermatology

*Regulation (EU) 2019/27*

Applicants shall be assessed as unfit, where they have an established dermatological condition which is likely to jeopardise the safe exercise of the privileges of the licence.

## AMC1 MED.B.085 Dermatology

*ED Decision 2019/002/R*

(a) If doubt exists about the fitness of applicants with eczema (exogenous and endogenous), severe psoriasis, bacterial infections, drug induced or bullous eruptions or urticaria, the AME should refer the case to the medical assessor of the licensing authority.

(b) Systemic effects of radiant or pharmacological treatment for a dermatological condition should be reviewed before a fit assessment may be considered.

(c) In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be considered.

## AMC2 MED.B.085 Dermatology

*ED Decision 2019/002/R*

In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be considered.

## MED.B.090 Oncology

*Regulation (EU) 2019/27*

(a) Before further consideration is given to their application, applicants with primary or secondary malignant disease shall undergo satisfactory oncological evaluation. Such applicants for a class 1 medical certificate shall be referred to the medical assessor of the licensing authority. Such applicants for a class 2 medical certificate shall be assessed in consultation with the medical assessor of the licensing authority.

(b) Applicants with a documented medical history or clinical diagnosis of an intracerebral malignant tumour shall be assessed as unfit.

## AMC1 MED.B.090 Oncology

*ED Decision 2019/002/R*

(a) Applicants who have been diagnosed with a malignant disease may be assessed as fit provided that:

(1) after primary treatment, there is no evidence of residual malignant disease likely to jeopardise flight safety;

(2) time appropriate to the type of tumour and primary treatment has elapsed;

(3) the risk of inflight incapacitation from a recurrence or metastasis is sufficiently low;

(4) there is no evidence of short or long-term sequelae from treatment. Special attention should be paid to applicants who have received anthracycline chemotherapy;

(5) satisfactory oncology follow-up reports are provided to the medical assessor of the licensing authority.

(b) An OML should be applied as appropriate.

(c) Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.

(d) Applicants with pre-malignant conditions of the skin may be assessed as fit if treated or excised as necessary and there is regular follow-up.

## AMC2 MED.B.090 Oncology

*ED Decision 2019/002/R*

(a) Applicants who have been diagnosed with a malignant disease may be considered for a fit assessment provided that:

(1) after primary treatment, there is no evidence of residual malignant disease likely to jeopardise flight safety;

(2) time appropriate to the type of tumour and primary treatment has elapsed;

(3) the risk of in-flight incapacitation from a recurrence or metastasis is sufficiently low;

(4) there is no evidence of short or long-term sequelae from treatment that may jeopardise flight safety;

(5) arrangements for an oncological follow-up have been made for an appropriate period of time.

(b) Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.

(c) Applicants with pre-malignant conditions of the skin may be assessed as fit if treated or excised as necessary and there is a regular follow-up.

# SECTION 3 – SPECIFIC REQUIREMENTS FOR LAPL MEDICAL CERTIFICATES

## MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*Regulation (EU) 2019/27*

(a) An applicant for a LAPL medical certificate shall be assessed based on aero-medical best practice.

(b) Special attention shall be given to the applicant's complete medical history.

(c) The initial assessment, all subsequent re-assessments after the licence holder reaches the age of 50 and any assessments in cases where the medical history of the applicant is not available to the examiner shall include at least all of the following:

(1) clinical examination;

(2) blood pressure;

(3) urine test;

(4) vision;

(5) hearing ability.

(d) After the initial assessment, subsequent re-assessments until the licence holder reaches the age of 50 shall include at least both of the following:

(1) an assessment of the LAPL holder's medical history;

(2) the items specified in point(c) as deemed necessary by the AeMC, AME or GMP in accordance with aero-medical best practice.

## AMC1 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

When a specialist evaluation is required under this section, the aero-medical assessment of the applicant should be performed by an AeMC, an AME or, in the case of AMC5 MED.B.095(d), by the medical assessor of the licensing authority.

## AMC2 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**CARDIOVASCULAR SYSTEM**

(a) Examination

Pulse and blood pressure should be recorded at each examination.

(b) General

(1) Cardiovascular risk factor assessment

An accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) requires cardiovascular evaluation.

(2) Aortic aneurysm

Applicants with an aortic aneurysm may be assessed as fit subject to satisfactory cardiological evaluation and a regular follow-up.

(3) Cardiac valvular abnormalities

(i) Applicants with a cardiac murmur may be assessed as fit if the murmur is assessed as being of no pathological significance.

(ii) Applicants with a cardiac valvular abnormality may be assessed as fit subject to satisfactory cardiological evaluation.

(4) Valvular surgery

After cardiac valve replacement or repair, a fit assessment may be considered, with an ORL if anticoagulation is needed, subject to satisfactory post-operative cardiological evaluation. Anticoagulation should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. The INR target range should be determined by the type of surgery performed. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence if the INR is within the target range, may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months.

(5) Other cardiac disorders

(i) Applicants with other cardiac disorders may be assessed as fit subject to satisfactory cardiological evaluation. A fit assessment may be considered, with an ORL if anticoagulation is needed. Anticoagulation should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. The INR target range should be determined by the type of surgery performed. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence if the INR is within the target range, may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months.

(ii) Applicants with symptomatic hypertrophic cardiomyopathy should be assessed as unfit.

(c) Blood pressure

(1) When the blood pressure consistently exceeds 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment, the applicant should be assessed as unfit.

(2) Applicants initiating medication for the control of blood pressure should be assessed as unfit until the absence of significant side effects has been established.

(d) Coronary artery disease

(1) Applicants with suspected myocardial ischaemia should undergo a cardiological evaluation before a fit assessment may be considered.

(2) Applicants with angina pectoris requiring medication for cardiac symptoms should be assessed as unfit.

(3) After an ischaemic cardiac event, including myocardial infarction or revascularisation, applicants without symptoms should have reduced cardiovascular risk factors to an appropriate level. Medication, when used to control cardiac symptoms, is not acceptable. All applicants should be on appropriate secondary prevention treatment.

(4) In cases (d)(1), (d)(2) and (d)(3), applicants who have had a satisfactory cardiological evaluation to include an exercise test or equivalent that is negative for ischaemia may be assessed as fit.

(e) Rhythm and conduction disturbances

(1) Applicants with a significant disturbance of cardiac rhythm or conduction should be assessed as unfit unless a cardiological evaluation concludes that the disturbance is not likely to interfere with the safe exercise of the privileges of the licence. A fit assessment may be considered, with an ORL if anticoagulation is needed. Anticoagulation should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. The INR target range should be determined by the type of surgery performed. Applicants who measure their INR on a 'near patient' testing system within 12 hours prior to flight and only exercise the privileges of their licence if the INR is within the target range, may be assessed as fit without the above-mentioned limitation. The INR results should be recorded and the results should be reviewed at each aero-medical assessment. Applicants taking anticoagulation medication not requiring INR monitoring, may be assessed as fit without the above-mentioned limitation in consultation with the medical assessor of the licensing authority after a stabilisation period of 3 months.

(2) Pre-excitation

Applicants with ventricular pre-excitation may be assessed as fit subject to satisfactory cardiological evaluation. Applicants with ventricular pre-excitation associated with a significant arrhythmia should be assessed as unfit.

(3) Automatic implantable defibrillating system

Applicants with an automatic implantable defibrillating system should be assessed as unfit.

(4) Pacemaker

A fit assessment may be considered subject to satisfactory cardiological evaluation.

# AMC3 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**RESPIRATORY SYSTEM**

(a) Applicants should undergo pulmonary morphological or functional tests when clinically indicated.

(b) Asthma and chronic obstructive pulmonary disease

Applicants with asthma or impairment of pulmonary function may be assessed as fit provided that the condition is considered stable with satisfactory pulmonary function and medication is compatible with flight safety. Systemic steroids may be acceptable provided that the dosage required is acceptable and there are no adverse side effects.

(c) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Investigation should be undertaken with respect to the possibility of systemic involvement. A fit assessment may be considered once the disease is inactive.

(2) Applicants with cardiac sarcoidosis should be assessed as unfit.

(d) Pneumothorax

(1) Applicants with spontaneous pneumothorax may be assessed as fit subject to satisfactory respiratory evaluation following recovery from a single spontaneous pneumothorax or following recovery from surgical intervention for a recurrent pneumothorax.

(2) Applicants with traumatic pneumothorax may be assessed as fit following recovery.

(e) Thoracic surgery

Applicants who have undergone thoracic surgery may be assessed as fit following recovery.

(f) Sleep apnoea syndrome/sleep disorder

Applicants with unsatisfactorily treated sleep apnoea syndrome should be assessed as unfit.

# AMC4 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**DIGESTIVE SYSTEM**

(a) Gallstones

Applicants with symptomatic gallstones should be assessed as unfit. A fit assessment may be considered following gallstone removal.

(b) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease may be assessed as fit provided that the disease is stable and not likely to interfere with the safe exercise of the privileges of the licence.

(c) Peptic ulceration

Applicants with peptic ulceration may be assessed as fit subject to satisfactory gastroenterological evaluation.

(d) Digestive tract and abdominal surgery

Applicants who have undergone a surgical operation:

(1) for herniae; or

(2) on the digestive tract or its adnexa, including a total or partial excision or diversion of any of these organs,

should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic, and there is only a minimal risk of secondary complication or recurrence.

(e) Pancreatitis

Applicants with pancreatitis may be assessed as fit after satisfactory recovery.

(f) Liver disease

Applicants with morphological or functional liver disease or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.

## AMC5 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**METABOLIC AND ENDOCRINE SYSTEMS**

(a) Metabolic, nutritional or endocrine dysfunction

Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit subject to demonstrated stability of the condition and satisfactory aero-medical evaluation.

(b) Obesity

Obese applicants may be assessed as fit if the excess weight is not likely to interfere with the safe exercise of the licence.

(c) Thyroid dysfunction

Applicants with thyroid disease may be assessed as fit once a stable euthyroid state is attained.

(d) Diabetes mellitus

(1) Applicants using antidiabetic medications that are not likely to cause hypoglycaemia may be assessed as fit.

(2) Applicants with diabetes mellitus Type 1 should be assessed as unfit.

(3) Applicants with diabetes mellitus Type 2 treated with insulin may be assessed as fit with limitations for revalidation if blood sugar control has been achieved and the process under (e) and (f) is followed. An ORL is required. A TML for 12 months may be needed to ensure compliance with the follow-up requirements below. Licence privileges should not include rotary aircraft flying.

(e) Aero-medical assessment by, or under the guidance of, the medical assessor of the licensing authority:

(1) A diabetology review at yearly intervals, including:

(i) symptom review;

(ii) review of data logging of blood sugar;

(iii) cardiovascular status. Exercise ECG at age 40, at 5-yearly intervals thereafter and on clinical indication, including an accumulation of risk factors;

(iv) nephropathy status.

(2) Ophthalmological review at yearly intervals, including:

(i) visual fields — Humphrey-perimeter;

(ii) retinae — full dilatation slit lamp examination;

(iii) cataract — clinical screening.

The development of retinopathy requires a full ophthalmological review.

(3) Blood testing at 6-monthly intervals:

(i) HbA1c;

(ii) renal profile;

(iii) liver profile;

(iv) lipid profile.

(4) Applicants should be assessed as temporarily unfit after:

(i) changes of medication/insulin leading to a change to the testing regime until stable blood sugar control can be demonstrated;

(ii) a single unexplained episode of severe hypoglycaemia until stable blood sugar control can be demonstrated.

(5) Applicants should be assessed as unfit in the following cases:

(i) loss of hypoglycaemic awareness;

(ii) development of retinopathy with any visual field loss;

(iii) significant nephropathy;

(iv) any other complication of the disease where flight safety may be jeopardised.

(f) Pilot responsibility

Blood sugar testing is carried out during non-operational and operational periods. A whole blood glucose measuring device with memory should be carried and used. Equipment for continuous glucose monitoring (CGMS) should not be used. Pilots should prove to the AME or AeMC or medical assessor of the licensing authority that testing has been performed as indicated below and with which results.

(1) Testing during non-operational periods: normally 3–4 times/day or as recommended by the treating physician, and on any awareness of hypoglycaemia.

(2) Testing frequency during operational periods:

(i) 120 minutes before departure;

(ii) <30 minutes before departure;

(iii) 60 minutes during flight;

(iv) 30 minutes before landing.

(3) Actions following glucose testing:

(i) 120 minutes before departure: if the test result is >15 mmol/l, piloting should not be commenced.

(ii) 10–15g of carbohydrate should be ingested and a re-test performed within 30 minutes if:

(A) any test result is <4,5 mmol/l;

(B) the pre-landing test measurement is missed or a subsequent go-around/diversion is performed.

## AMC6 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**HAEMATOLOGY**

Applicants with a haematological condition, such as:

(a) abnormal haemoglobin including, but not limited to, anaemia, erythrocytosis or haemoglobinopathy;

(b) coagulation, haemorrhagic or thrombotic disorder;

(c) significant lymphatic enlargement;

(d) acute or chronic leukaemia;

(e) splenomegaly;

may be assessed as fit subject to satisfactory aero-medical evaluation. If anticoagulation is being used as treatment, refer to AMC2 MED.B.095(b)(4).

## AMC7 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**GENITOURINARY SYSTEM**

(a) Applicants with a genitourinary disorder, such as:

(1) renal disease; or

(2) one or more urinary calculi, or a history of renal colic

may be assessed as fit subject to satisfactory renal and urological evaluation, as applicable.

(b) Applicants who have undergone a major surgical operation on the genitourinary system or its adnexa may be assessed as fit following recovery.

(c) Applicants who have undergone renal transplantation may be assessed as fit subject to satisfactory renal evaluation.

## AMC8 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**INFECTIOUS DISEASE**

(a) Applicants who are HIV positive may be assessed as fit subject to satisfactory aero-medical evaluation.

(b) Applicants with other chronic infections may be assessed as fit provided the infections are not likely to interfere with the safe exercise of the privileges of the licence.

## AMC9 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**OBSTETRICS AND GYNAECOLOGY**

(a) Pregnancy

Holders of a LAPL medical certificate should only exercise the privileges of their licences until the end of the 26th week of gestation under routine antenatal care.

(b) Applicants who have undergone a major gynaecological operation may be assessed as fit after recovery.

## AMC10 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**MUSCULOSKELETAL SYSTEM**

Applicants should have satisfactory functional use of the musculoskeletal system to enable the safe exercise of the privileges of the licence.

## AMC11 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**MENTAL HEALTH**

(a) Applicants with a mental or behavioural disorder due to use or misuse of alcohol or other psychoactive substances, with or without dependency, should be assessed as unfit. A fit assessment may be considered after a period of two years of documented sobriety or freedom from psychoactive substance use or misuse, subject to satisfactory psychiatric evaluation after successful treatment. At revalidation or renewal, a fit assessment may be considered earlier. Depending on the individual case, treatment and evaluation may include in-patient treatment of some weeks followed by ongoing checks, including blood testing and peer reports, which may be required indefinitely.

(b) Applicants with a history of, or the occurrence of, a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased, and the risk of recurrence is minimal.

(c) Applicants with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder should be assessed as unfit. A fit assessment may only be considered if the original diagnosis was inappropriate or inaccurate as confirmed by psychiatric evaluation or, in the case of a single episode of delirium, provided that the applicant has suffered no permanent impairment.

(d) Psychoactive substances

Applicants who use or misuse psychoactive substances or psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with appropriate limitation(s) may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed.

(e) Applicants with a psychiatric condition, such as:

(1) mood disorder;

(2) neurotic disorder;

(3) personality disorder;

(4) mental or behavioural disorder

should undergo satisfactory psychiatric evaluation before a fit assessment may be considered.

(f) Applicants with a history of significant or repeated acts of deliberate self-harm should undergo satisfactory psychiatric or psychological evaluation or both before a fit assessment may be considered.

(g) Psychiatric evaluations and reviews may include reports from the applicant's flight instructor.

(h) Applicants with a psychological disorder may need to be referred for psychological opinion and advice.

(i) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC, GMP or medical assessor of the licensing authority as appropriate, detailing their opinion and recommendation.

## AMC12 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**NEUROLOGY**

(a) Epilepsy and seizures

(1) Applicants with an established diagnosis of and under treatment for epilepsy should be assessed as unfit. A re-assessment after all treatment has been stopped for at least 5 years should include a review of neurological reports.

(2) Applicants may be assessed as fit if:

(i) there is a history of a single afebrile epileptiform seizure considered to have a very low risk of recurrence;

(ii) there has been no recurrence after at least 5 years off treatment;

(iii) a cause has been identified and treated and there is no evidence of continuing predisposition to epilepsy.

(b) Neurological disease

Applicants with any disease of the nervous system which is likely to cause a hazard to flight safety should be assessed as unfit. However, in certain cases, including cases of functional loss associated with stable disease, a fit assessment may be considered after full evaluation including, if necessary, a medical flight test.

(c) Migraine

Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, therapy. Appropriate limitation(s) may apply.

(d) Head injury

Applicants with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury may be assessed as fit if there has been a full recovery and the risk of epilepsy is sufficiently low. An evaluation by a neurologist may be required depending on the staging of the original injury.

(e) Spinal or peripheral nerve injury

Applicants with a history or diagnosis of spinal or peripheral nerve injury or a disorder of the nervous system due to a traumatic injury may be assessed as fit if neurological evaluation is satisfactory and the conditions of AMC10 MED.B.095 are satisfied.

(f) Vascular deficiencies

Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC10 MED.B.095 are satisfied. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.

## AMC13 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**VISUAL SYSTEM**

(a) Applicants should not possess any abnormality of the function of the eyes or their adnexa or any active pathological condition, congenital or acquired, acute or chronic, or any sequelae of eye surgery or trauma, which is likely to interfere with the safe exercise of the privileges of the applicable licence.

(b) Eye examination

The examination should include visual acuities (near, intermediate and distant vision) and visual field.

(c) Visual acuity

(1) Visual acuity with or without corrective lenses should be 6/9 (0,7) binocularly and 6/12 (0,5) in each eye.

(2) Applicants who do not meet the required visual acuity should be assessed by an AME or AeMC, taking into account the privileges of the licence held and the risk involved.

(3) Applicants should be able to read, binocularly, an N5 chart (or equivalent) at 30-50 cm and an N14 chart (or equivalent) at 100 cm, with correction if prescribed (Refer to GM1 MED.B.070).

(d) Visual acuity

Applicants with substandard vision in one eye may be assessed as fit if the better eye:

(1) achieves distant visual acuity of 6/6 (1,0), corrected or uncorrected;

(2) achieves distant visual acuity less than 6/6 (1,0) but not less than 6/9 (0,7), after ophthalmological evaluation.

(e) Visual field defects

Applicants with a visual field defect may be assessed as fit if the binocular visual field or, in the case of monocularity, the monocular visual field is acceptable.

(f) Eye surgery

(1) After refractive surgery, a fit assessment may be considered, provided that there is satisfactory stability of refraction, there are no post-operative complications and no significant increase in glare sensitivity.

(2) After cataract, retinal or glaucoma surgery a fit assessment may be considered once recovery is complete.

(g) Visual correction

Correcting lenses should permit the licence holder to meet the visual requirements at all distances.

## AMC14 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**COLOUR VISION**

Applicants for a night rating should correctly identify 9 of the first 15 plates of the 24-plate edition of Ishihara pseudoisochromatic plates or should be colour safe.

# AMC15 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**OTORHINOLARYNGOLOGY (ENT)**

(a) Hearing

(1) Applicants should understand correctly conversational speech when tested with or without hearing aids at a distance of 2 metres from and with the applicant's back turned towards the examiner.

(2) If the hearing requirements can only be met with the use of hearing aid(s), the hearing aid(s) should provide optimal hearing function, be well-tolerated, and be suitable for aviation purposes.

(3) Applicants with hypoacusis should demonstrate satisfactory functional hearing ability.

(4) Applicants with profound deafness or major disorder of speech, or both, may be assessed as fit with an SSL such as 'limited to areas and operations where the use of radio is not mandatory'. The aircraft should be equipped with appropriate alternative warning devices in lieu of sound warnings.

(b) Ear conditions

Applicants with:

(1) an active pathological process of the internal or middle ear;

(2) unhealed perforation or dysfunction of the tympanic membrane(s);

(3) disturbance of vestibular function;

(4) significant restriction of the nasal passages;

(5) sinus dysfunction;

(6) significant malformation or significant infection of the oral cavity or upper respiratory tract; or

(7) significant disorder of speech or voice

should undergo further examination to establish that the condition does not interfere with the safe exercise of the privileges of the licence.

# AMC16 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**DERMATOLOGY**

In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be considered.

# AMC17 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**ONCOLOGY**

(a) In the case of malignant disease, applicants may be considered for a fit assessment if:

(1) there is no evidence of residual malignant disease likely to jeopardise flight safety;

(2) time appropriate to the type of tumour has elapsed since the end of primary treatment;

(3) the risk of in-flight incapacitation from a recurrence or metastasis is sufficiently low;

(4) there is no evidence of short or long-term sequelae from treatment that may jeopardise flight safety.

(b) Arrangements for an oncological follow-up should be made for an appropriate period of time.

(c) Applicants with an established history or clinical diagnosis of intracerebral malignant tumour should be assessed as unfit.

# GM1 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**DIABETES MELLITUS TYPE 2 TREATED WITH INSULIN – GENERAL**

(a) Pilots and their treating physician should be aware that if the HbA1c target level was set to normal (non-diabetic) levels, this will significantly increase the chance of hypoglycaemia. For safety reasons the target level of HbA1c is therefore set to 7,5–8,5 % even though there is evidence that lower HbA1c levels are correlated with fewer diabetic complications.

(b) The safety pilot should be briefed pre-flight on the potential condition of the pilot. The results of blood sugar testing before and during flight should be shared with the safety pilot for the acceptability of the values obtained.

# GM2 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**DIABETES MELLITUS TYPE 2 TREATED WITH INSULIN – CONVERSION TABLE FOR HbA1c IN % AND MMOL/MOL**

| HbA1c in % | HbA1c in mmol/mol |
|---|---|
| 4,7 | 28 |
| 5,0 | 31 |
| 5,3 | 34 |
| 5,6 | 38 |
| 5,9 | 41 |
| 6,2 | 44 |
| 6,5 | 48 |
| 6,8 | 51 |
| 7,4 | 57 |
| 8,0 | 64 |

| | |
|---|---|
| 8,6 | 70 |
| 9,2 | 77 |
| 9,8 | 84 |
| 10,4 | 90 |
| 11,6 | 103 |

## GM3 MED.B.095 Medical examination and assessment of applicants for LAPL medical certificates

*ED Decision 2019/002/R*

**MOOD DISORDER**

After full recovery from a mood disorder and after full consideration of the individual case, a fit assessment may be considered, depending on the characteristics and gravity of the mood disorder. If stability on maintenance psychoactive medication is confirmed, a fit assessment may be considered. If the dosage or type of medication is changed, a further evaluation may be required until stability is confirmed.

# SUBPART C – REQUIREMENTS FOR MEDICAL FITNESS OF CABIN CREW

## SECTION 1 – GENERAL REQUIREMENTS

### MED.C.001 General

*Regulation (EU) No 1178/2011*

Cabin crew members shall only perform the duties and responsibilities required by aviation safety rules on an aircraft if they comply with the applicable requirements of this Part.

### MED.C.005 Aero-medical assessments

*Regulation (EU) No 1178/2011*

(a) Cabin crew members shall undergo aero-medical assessments to verify that they are free from any physical or mental illness which might lead to incapacitation or an inability to perform their assigned safety duties and responsibilities.

(b) Each cabin crew member shall undergo an aero-medical assessment before being first assigned to duties on an aircraft, and after that at intervals of maximum 60 months.

(c) Aero-medical assessments shall be conducted by an AME, AeMC, or by an OHMP if the requirements of MED.D.040 are complied with.

### AMC1 MED.C.005 Aero-medical assessments

*ED Decision 2019/002/R*

(a) When conducting aero-medical examinations and assessments of cabin crew members, as applicable, their medical fitness should be assessed with particular regard to their physical and mental ability to:

(1) undergo the training required for cabin crew to acquire and maintain competence, e.g. actual fire-fighting, slide descending, using Protective Breathing Equipment (PBE) in a simulated smoke-filled environment, providing first aid;

(2) manipulate the aircraft systems and emergency equipment to be used by cabin crew, e.g. cabin management systems, doors/exits, escape devices, fire extinguishers, taking also into account the class and type of aircraft operated, e.g. narrow-bodied or wide-bodied, single/multi-deck, single/multi-cabin crew operation;

(3) continuously tolerate the aircraft environment whilst performing duties, e.g. altitude, pressure, re-circulated air, noise; and the type of operations such as short/medium/long/ultra long haul; and

(4) perform the required duties and responsibilities efficiently during normal and abnormal operations, and in emergency situations and psychologically demanding circumstances, e.g. assistance to crew members and passengers in case of decompression; stress management, decision-making, crowd control and effective crew coordination, management of disruptive passengers and of security threats. When relevant, operating as single cabin crew should also be taken into account when assessing the medical fitness of cabin crew.

(b) Intervals

(1) The interval between aero-medical assessments should be determined by the competent authority. The intervals established by the competent authority apply to cabin crew members who:

(i) undergo aero-medical assessments by an AME, AeMC or OHMP under the oversight of that competent authority; or

(ii) are employed by an operator under the oversight of that competent authority.

(2) The interval between aero-medical assessments may be reduced by the AME, AeMC or OHMP for medical reasons and in accordance with MED.C.035.

(3) Aero-medical assessments for the revalidation of a cabin crew medical report may be undertaken up to 45 days prior to the expiry date of the previous medical report. The validity period of the aero-medical assessment should be calculated from the expiry date of the previous aero-medical assessment.

# SECTION 2 – REQUIREMENTS FOR AERO-MEDICAL ASSESSMENT OF CABIN CREW

## MED.C.020 General

*Regulation (EU) No 1178/2011*

Cabin crew members shall be free from any:

(a) abnormality, congenital or acquired;

(b) active, latent, acute or chronic disease or disability;

(c) wound, injury or sequelae from operation; and

(d) effect or side effect of any prescribed or non-prescribed therapeutic, diagnostic or preventive medication taken that would entail a degree of functional incapacity which might lead to incapacitation or an inability to discharge their safety duties and responsibilities.

## MED.C.025 Content of aero-medical assessments

*Regulation (EU) No 1178/2011*

(a) An initial aero-medical assessment shall include at least:

(1) an assessment of the applicant cabin crew member's medical history; and

(2) a clinical examination of the following:

(i) cardiovascular system;

(ii) respiratory system;

(iii) musculoskeletal system;

(iv) otorhino-laryngology;

(v) visual system; and

(vi) colour vision.

(b) Each subsequent aero-medical re-assessment shall include:

(1) an assessment of the cabin crew member's medical history; and

(2) a clinical examination if deemed necessary in accordance with aero-medical best practice.

(c) For the purpose of (a) and (b), in case of any doubt or if clinically indicated, a cabin crew member's aero-medical assessment shall also include any additional medical examination, test or investigation that are considered necessary by the AME, AeMC or OHMP.

## AMC1 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

Aero-medical examinations and assessments of cabin crew members should be conducted in accordance with AMC2 to AMC18 MED.C.025.

# AMC2 MED.C.025 Content of aero-medical assessments

ED Decision 2019/002/R

**CARDIOVASCULAR SYSTEM**

(a) Examination

(1) A standard 12-lead resting electrocardiogram (ECG) and report should be completed on clinical indication, at the first examination after the age of 40 and then at least every five years after the age of 50. If cardiovascular risk factors such as smoking, abnormal cholesterol levels or obesity are present, the intervals of resting ECGs should be reduced to two years.

(2) Extended cardiovascular assessment should be required when clinically indicated.

(b) Cardiovascular system - general

(1) Cabin crew members with any of the following conditions:

(i) aneurysm of the thoracic or supra-renal abdominal aorta, before surgery;

(ii) significant functional abnormality of any of the heart valves; or

(iii) heart or heart/lung transplantation

should be assessed as unfit.

(2) Cabin crew members with an established diagnosis of one of the following conditions:

(i) peripheral arterial disease before or after surgery;

(ii) aneurysm of the abdominal aorta, before or after surgery;

(iii) minor cardiac valvular abnormalities;

(iv) after cardiac valve surgery;

(v) abnormality of the pericardium, myocardium or endocardium;

(vi) congenital abnormality of the heart, before or after corrective surgery;

(vii) a cardiovascular condition requiring systemic anticoagulation;

(viii) vasovagal syncope of uncertain cause;

(ix) arterial or venous thrombosis; or

(x) pulmonary embolism

should be evaluated by a cardiologist before a fit assessment may be considered.

(c) Thromboembolic disorders

Whilst anticoagulation therapy is initiated, cabin crew members should be assessed as unfit. After a period of stable anticoagulation, a fit assessment may be considered with limitation(s), as appropriate. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range and the haemorrhagic risk is acceptable. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment may be considered after a stabilisation period of 3 months. Cabin crew members with pulmonary embolism should also be evaluated by a cardiologist. Following cessation of anticoagulant therapy, for any indication, cabin crew members should undergo a re-assessment.

(d) Syncope

(1) In the case of a single episode of vasovagal syncope which can be satisfactorily explained, a fit assessment may be considered.

(2) Cabin crew members with a history of recurrent vasovagal syncope should be assessed as unfit. A fit assessment may be considered after a 6-month period without recurrence, provided cardiological evaluation is satisfactory. Neurological review may be indicated.

(e) Blood pressure

Blood pressure should be recorded at each examination.

(1) The blood pressure should be within normal limits and should not consistently exceed 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment, taking into account other risk factors.

(2) Cabin crew members initiating medication for the control of blood pressure should be assessed as unfit until the absence of any significant side effects has been established and verification that the treatment is compatible with the safe exercise of cabin crew duties has been achieved.

(f) Coronary artery disease

(1) Cabin crew members with:

(i) cardiac ischaemia;

(ii) symptomatic coronary artery disease; or

(iii) symptoms of coronary artery disease controlled by medication

should be assessed as unfit.

(2) Cabin crew members who are asymptomatic after myocardial infarction or surgery for coronary artery disease should have fully recovered before a fit assessment may be considered. The affected cabin crew members should be on appropriate secondary prevention treatment.

(g) Rhythm/conduction disturbances

(1) Cabin crew members with any significant disturbance of cardiac conduction or rhythm should undergo cardiological evaluation before a fit assessment may be considered.

(2) Cabin crew members with a history of:

(i) ablation therapy; or

(ii) pacemaker implantation

should undergo satisfactory cardiovascular evaluation before a fit assessment may be made.

(3) Cabin crew members with:

(i) symptomatic sinoatrial disease;

(ii) symptomatic hypertrophic cardiomyopathy

(iii) complete atrioventricular block;

(iv) symptomatic QT prolongation;

(v) an automatic implantable defibrillating system; or

(vi) a ventricular anti-tachycardia pacemaker

should be assessed as unfit.

## AMC3 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**RESPIRATORY SYSTEM**

(a) Cabin crew members with significant impairment of pulmonary function should be assessed as unfit. A fit assessment may be considered once pulmonary function has recovered and is satisfactory.

(b) Cabin crew members should undergo pulmonary morphological or functional tests on when clinically indicated.

(c) Cabin crew members with a history or established diagnosis of:

(1) asthma;

(2) active inflammatory disease of the respiratory system;

(3) active sarcoidosis;

(4) pneumothorax;

(5) sleep apnoea syndrome/sleep disorder; or

(6) major thoracic surgery

should undergo respiratory evaluation with a satisfactory result before a fit assessment may be considered.

(d) Cabin crew members who have undergone a pneumonectomy should be assessed as unfit.

## AMC4 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**DIGESTIVE SYSTEM**

(a) Cabin crew members with any disease or sequelae of surgical intervention in any part of the digestive tract or its adnexa likely to cause incapacitation in flight, in particular any obstruction due to stricture or compression, should be assessed as unfit.

(b) Cabin crew members should be free from herniae that might give rise to incapacitating symptoms.

(c) Cabin crew members with disorders of the gastro-intestinal system, including:

(1) recurrent severe dyspeptic disorder requiring medication;

(2) peptic ulceration;

(3) pancreatitis;

(4) symptomatic gallstones;

(5) an established diagnosis or history of chronic inflammatory bowel disease;

(6) after surgical operation on the digestive tract or its adnexa, including surgery involving total or partial excision or a diversion of any of these organs;

(7) morphological or functional liver disease; or

(8) after surgery, including liver transplantation

may be assessed as fit subject to satisfactory gastroenterological evaluation.

## AMC5 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**METABOLIC AND ENDOCRINE SYSTEMS**

(a) Cabin crew members should not possess any functional or structural metabolic, nutritional or endocrine disorder which is likely to interfere with the safe exercise of their duties and responsibilities.

(b) Cabin crew members with metabolic, nutritional or endocrine dysfunction may be assessed as fit, subject to demonstrated stability of the condition and satisfactory aero-medical evaluation.

(c) Diabetes mellitus

(1) Cabin crew members with diabetes mellitus requiring insulin may be assessed as fit:

(i) if it can be demonstrated that adequate blood sugar control has been achieved and hypoglycaemia awareness is established and maintained; and

(ii) in the absence, within the preceding 12 months, of any;

(A) hospitalisation related to diabetes; or

(B) hypoglycaemia that resulted in a seizure, loss of consciousness, impaired cognitive function or that required the intervention by another party; or

(C) episode of hypoglycaemia unawareness.

(2) Limitations should be imposed as appropriate. A limitation to undergo specific medical examinations (SIC) and a restriction to operate only in multi-cabin crew operations (MCL) should be placed as a minimum.

(3) Cabin crew members with diabetes mellitus not requiring insulin may be assessed as fit if it can be demonstrated that adequate blood sugar control has been achieved and hypoglycaemia awareness, if applicable considering the medication, is achieved.

## AMC6 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**HAEMATOLOGY**

Cabin crew members with a haematological condition, such as:

(a) abnormal haemoglobin including, but not limited to, anaemia, erythrocytosis or haemoglobinopathy;

(b) coagulation, haemorrhagic or thrombotic disorder;

(c) significant lymphatic enlargement;

(d) acute or chronic leukaemia; or

(e) splenomegaly

may be assessed as fit subject to satisfactory aero-medical evaluation. If anticoagulation is being used as treatment, refer to AMC2 MED.C.025(c).

## AMC7 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**GENITOURINARY SYSTEM**

(a) Urine analysis should form part of every aero-medical examination and assessment. The urine should not contain any abnormal element(s) considered to be of pathological significance.

(b) Cabin crew members with any disease or sequelae of surgical procedures on the kidneys or the urinary tract, in particular any obstruction due to stricture or compression likely to cause incapacitation should be assessed as unfit.

(c) Cabin crew members with a genitourinary disorder, such as:

(1) renal disease; or

(2) a history of renal colic due to one or more urinary calculi

may be assessed as fit subject to satisfactory renal/urological evaluation.

(d) Cabin crew members who have undergone a major surgical operation in the genitourinary apparatus involving a total or partial excision or a diversion of its organs should be assessed as unfit and be re-assessed after recovery before a fit assessment may be made.

(e) Cabin crew members who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and tolerated with only minimal immuno-suppressive therapy after at least 12 months. A requirement to undergo specific medical examinations (SIC) and a restriction to operate only in multi-cabin crew operations (MCL) should be considered.

(f) Cabin crew members requiring dialysis should be assessed as unfit.

## AMC8 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**INFECTIOUS DISEASE**

Cabin crew members who are HIV positive may be assessed as fit if investigation provides no evidence of clinical disease and subject to satisfactory aero-medical evaluation.

## AMC9 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**OBSTETRICS AND GYNAECOLOGY**

(a) Cabin crew members who have undergone a major gynaecological operation should be assessed as unfit until after recovery.

(b) Pregnancy

(1) A pregnant cabin crew member may be assessed as fit only during the first 16 weeks of gestation following review of the obstetric evaluation by the AME or OHMP.

(2) A limitation not to perform duties as single cabin crew member should be considered.

(3) The AME or OHMP should provide written advice to the cabin crew member and supervising physician regarding potentially significant complications of pregnancy resulting from flying duties.

## AMC10 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**MUSCULOSKELETAL SYSTEM**

(a) Cabin crew members should have sufficient standing height, arm and leg length and muscular strength for the safe exercise of their duties and responsibilities.

(b) Cabin crew members should have satisfactory functional use of the musculoskeletal system. Particular attention should be paid to emergency procedures and evacuation, and related training.

(c) Cabin crew members with any significant sequelae from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery require full evaluation prior to a fit assessment.

(d) Cabin crew members with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission or is stable and the affected cabin crew member is not taking any medication that may lead to unfitness.

## AMC11 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**MENTAL HEALTH**

(a) Cabin crew members with a mental or behavioural disorder due to use or misuse of alcohol or other psychoactive substances should be assessed as unfit pending recovery and freedom from psychoactive substance use or misuse and subject to satisfactory psychiatric evaluation after successful treatment.

(b) Cabin crew members with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder should be assessed as unfit.

(c) Cabin crew members with a psychiatric condition such as:

(1) mood disorder;

(2) neurotic disorder;

(3) personality disorder; or

(4) mental or behavioural disorder

should undergo satisfactory psychiatric evaluation before a fit assessment may be considered.

(d) Cabin crew members with a history of a single or repeated acts of deliberate self-harm should be assessed as unfit. Cabin crew members should undergo satisfactory psychiatric evaluation before a fit assessment may be considered.

(e) Where there is established evidence that a cabin crew member has a psychological disorder, he/she should be referred for psychological opinion and advice.

(f) The psychological evaluation may include a collection of biographical data, the review of aptitudes, and personality tests and psychological interview.

(g) The psychologist should submit a report to the AME or OHMP, detailing the results and recommendation.

## AMC12 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**NEUROLOGY**

(a) Cabin crew members with an established history or clinical diagnosis of:

(1) epilepsy; or

(2) recurring episodes of disturbance of consciousness of uncertain cause

should be assessed as unfit.

(b) Cabin crew members with an established history or clinical diagnosis of:

(1) epilepsy without recurrence after 5 years of age and without treatment for more than 10 years;

(2) epileptiform EEG abnormalities and focal slow waves;

(3) progressive or non-progressive disease of the nervous system;

(4) inflammatory disease of the central or peripheral nervous system;

(5) migraine;

(6) a single episode of disturbance of consciousness of uncertain cause;

(7) loss of consciousness after head injury;

(8) penetrating brain injury; or

(9) spinal or peripheral nerve injury

should undergo further evaluation before a fit assessment may be considered.

(c) Cabin crew members with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological review and musculoskeletal assessments are satisfactory.

## AMC13 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**VISUAL SYSTEM**

(a) Examination

(1) a routine eye examination should form part of the initial and all further examinations and assessments; and

(2) an extended eye examination should be undertaken by an eye specialist when clinically indicated.(Refer to GM2 MED.B.070)

(b) Distant visual acuity, with or without correction, should be with both eyes 6/9 (0,7) or better.

(c) Cabin crew members should be able to read an N5 chart (or equivalent) at 30–50 cm, with correction if prescribed (Refer to GM1 MED.B.070).

(d) The binocular visual field or, in the case of monocularity, the monocular visual field should be acceptable.

(e) Cabin crew members who have undergone refractive surgery may be assessed as fit subject to satisfactory ophthalmic evaluation.

(f) Cabin crew members with diplopia should be assessed as unfit.

(g) Spectacles and contact lenses:

If satisfactory visual function is achieved only with the use of correction:

(1) in the case of myopia or hyperopia or both, spectacles or contact lenses should be worn whilst on duty;

(2) in the case of presbyopia, spectacles should be readily available for immediate use;

(3) the correction should provide optimal visual function and be well-tolerated;

(4) a spare set of similarly correcting spectacles should be readily available for immediate use whilst on duty;

(5) orthokeratologic lenses should not be used.

## AMC14 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**COLOUR VISION**

Cabin crew members should be able to correctly identify 9 of the first 15 plates of the 24-plate edition of Ishihara pseudoisochromatic plates. Alternatively, cabin crew members should demonstrate the ability to readily perceive those colours of which the perception is required for the safe performance of their duties.

## AMC15 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**OTORHINOLARYNGOLOGY (ENT)**

(a) Hearing should be satisfactory for the safe exercise of cabin crew duties and responsibilities. Cabin crew with hypoacusis should demonstrate satisfactory functional hearing abilities.

(b) Examination

(1) An ear, nose and throat (ENT) examination should form part of all examinations and assessments. A tympanometry or equivalent should be performed at the initial examination and when clinically indicated.

(2) Hearing should be tested at all examinations and assessments:

(i) the cabin crew member should understand correctly conversational speech when tested with each ear at a distance of 2 metres from and with the cabin crew member's back turned towards the examiner;

(ii) notwithstanding (b)(2)(i), hearing should be tested with pure tone audiometry at the initial examination and when clinically indicated;

(iii) at initial examination the cabin crew member should not have a hearing loss of more than 35 dB at any of the frequencies 500 Hz, 1 000 Hz or 2 000 Hz, or more than 50 dB at 3 000 Hz, in either ear separately.

(3) If the hearing requirements can be met only with the use of hearing aid(s), the hearing aid(s) should provide optimal hearing function, be well-tolerated, and suitable for aviation purposes.

(c) Cabin crew members with:

(1) an active pathological process of the internal or middle ear;

(2) unhealed perforation or dysfunction of the tympanic membrane(s);

(3) disturbance of vestibular function;

(4) significant restriction of the nasal passages;

(5) sinus dysfunction;

(6) significant malformation or significant infection of the oral cavity or upper respiratory tract;

(7) significant disorder of speech or voice

should undergo further examination to establish that the condition does not interfere with the safe exercise of their duties and responsibilities.

## AMC16 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**DERMATOLOGY**

In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be made.

## AMC17 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**ONCOLOGY**

(a) After treatment for malignant disease, cabin crew members should undergo satisfactory oncological and aero-medical evaluation before a fit assessment may be considered.

(b) Cabin crew members with an established history or clinical diagnosis of intracerebral malignant tumour should be assessed as unfit. Considering the histology of the tumour, a fit assessment may be considered after successful treatment and recovery.

## GM1 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

(a) When conducting aero-medical examinations and assessments, typical cabin crew duties as listed in (b) and (c), particularly those to be performed during abnormal operations and emergency situations, and cabin crew responsibilities to the travelling public should be considered in order to identify:

(1) any physical and/or mental conditions that could be detrimental to the performance of the duties required from cabin crew; and

(2) which examination(s), test(s) or investigation(s) should be undergone to complete an appropriate aero-medical assessment.

(b) Main cabin crew duties and responsibilities during day-to-day normal operations

(1) During pre/post-flight ground operations with/without passengers on board:

(i) monitoring of situation inside the aircraft cabin and awareness of conditions outside the aircraft including observation of visible aircraft surfaces and information to flight crew of any surface contamination such as ice or snow;

(ii) assistance to special categories of passengers (SCPs) such as infants and children (accompanied or unaccompanied), persons with disabilities or reduced mobility, medical cases with or without medical escort, and inadmissible persons, deportees and passengers in custody;

(iii) observation of passengers (any suspicious behaviour, passengers under the influence of alcohol and/or drugs, mentally disturbed), observation of potential able-bodied persons, crowd control during boarding and disembarkation;

(iv) safe stowage of cabin luggage, safety demonstrations and cabin secured checks, management of passengers and ground services during re-fuelling, observation of use of portable electronic devices;

(v) preparedness to carry out safety and emergency duties at any time, and security alertness.

(2) During flight:

(i) operation and monitoring of aircraft systems, surveillance of the cabin, lavatories, galleys, crew areas and flight crew compartment;

(ii) coordination with flight crew on situation in the cabin and turbulence events/effects;

(iii) management and observation of passengers (consumption of alcohol, behaviour, potential medical issues), observation of use of portable electronic devices;

(iv) safety and security awareness and preparedness to carry out safety and emergency duties at any time, and cabin secured checks prior to landing.

(c) Main cabin crew duties and responsibilities during abnormal and emergency operations

(1) In case of planned or unplanned emergency evacuation: briefing and/or commands to passengers including SCPs and selection and briefing to able-bodied persons; crowd control monitoring and evacuation conduct including in the absence of command from the flight crew; post-evacuation duties including assistance, first aid and management of survivors and survival in particular environments; activation of applicable communication means towards search and rescue services.

(2) In case of decompression: checking of crew members, passengers, cabin, lavatories, galleys, crew rest areas and flight crew compartment, and administering oxygen to crew members and passengers as necessary.

(3) In case of pilot incapacitation: secure pilot in his/her seat or remove from flight crew compartment; administer first aid and assist operating pilot as required.

(4) In case of fire or smoke: identify source/cause/type of fire/smoke to perform the necessary required actions; coordinate with other cabin crew members and flight crew; select appropriate extinguisher/agent and fight the fire using portable breathing equipment (PBE), gloves, and protective clothing as required; management of necessary passengers' movement if possible; instructions to passengers to prevent smoke

inhalation/suffocation; give first aid as necessary; monitor the affected area until landing; preparation for possible emergency landing.

(5) In case of first aid and medical emergencies: assistance to crew members and/or passengers; correct assessment and correct use of therapeutic oxygen, defibrillator, first-aid kits/emergency medical kit contents as required; management of events, of incapacitated person(s) and of other passengers; coordination and effective communication with other crew members, in particular when medical advice is transmitted by frequency to flight crew or by a telecommunication connection.

(6) In case of disruptive passenger behaviour: passenger management as appropriate including use of restraint technique as considered required.

(7) In case of security threats (bomb threat on ground or in-flight and/or hijack): control of cabin areas and passengers' management as required by the type of threat, management of suspicious device, protection of flight crew compartment door.

(8) In case of handling of dangerous goods: observing safety procedures when handling the affected device, in particular when handling chemical substances that are leaking; protection and management of self and passengers and effective coordination and communication with other crew members.

## GM2 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**DIABETES MELLITUS TREATED WITH INSULIN**

When considering a fit assessment for cabin crew with diabetes mellitus requiring insulin, account should be taken of the IATA Guidelines on Insulin-Treated Diabetes (Cabin Crew), as last amended.

## GM3 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**COLOUR VISION – GENERAL**

Examples of colours of which the perception is required for the safe performance of cabin crew members' duties are: cabin crew indication panels, pressure gauges of emergency equipment (e.g. fire extinguishers) and cabin door status.

## GM4 MED.C.025 Content of aero-medical assessments

*ED Decision 2019/002/R*

**OTORHINOLARYNGOLOGY (ENT) – PURE TONE AUDIOGRAM**

The pure tone audiogram may also cover the 4 000 Hz frequency for early detection of decrease in hearing.

# SECTION 3 – ADDITIONAL REQUIREMENTS FOR APPLICANTS FOR, OR HOLDERS OF, A CABIN CREW ATTESTATION

## MED.C.030 Cabin crew medical report

*Regulation (EU) No 1178/2011*

(a) After completion of each aero-medical assessment, applicants for, and holders of, a cabin crew attestation:

(1) shall be provided with a cabin crew medical report by the AME,AeMC or OHMP; and

(2) shall provide the related information, or a copy of their cabin crew medical report to the operator(s) employing their services.

(b) Cabin crew medical report

A cabin crew medical report shall indicate the date of the aero-medical assessment, whether the cabin crew member has been assessed fit or unfit, the date of the next required aero-medical assessment and, if applicable, any limitation(s). Any other elements shall be subject to medical confidentiality in accordance with MED.A.015.

## AMC1 MED.C.030 Cabin crew medical report

*ED Decision 2019/002/R*

The cabin crew medical report to be provided in writing to the applicants for, and holders of, a cabin crew attestation:

(a) should be issued in the national language(s) and/or in English; and

(b) should include the following elements:

(1) The State where the aero-medical assessment of the Cabin Crew Attestation (CCA) applicant/holder was conducted (I);

(2) Last and first name of the CCA applicant/holder (IV);

(3) Date of birth of the CCA applicant/holder (*dd/mm/yyyy*) (XIV);

(4) Nationality of the CCA applicant/holder (VI);

(5) Signature of the CCA applicant/holder (VII);

(6) Aero-medical assessment result (fit or unfit) (II);

(7) Expiry date of the previous cabin crew medical report (*dd/mm/yyyy*);

(8) Date of issue (*dd/mm/yyyy*) and signature of the AeMC, AME, or OHMP (X);

(9) Date of the aero-medical assessment (*dd/mm/yyyy*);

(10) Seal or stamp of the AeMC, AME or OHMP (XI);

(11) Limitation(s), if applicable (XII);

(12) Expiry date of medical report (*dd/mm/yyyy*) (IX).

# GM1 MED.C.030(b) Cabin crew medical report

ED Decision 2019/002/R

**GENERAL**

The format of the cabin crew medical report may be as shown in the example below, with the size of each sheet being 1/8 of A4.

| | | |
|---|---|---|
| State of issue<br><br>CABIN CREW MEDICAL REPORT<br>FOR CABIN CREW ATTESTATION (CCA)<br>APPLICANT OR HOLDER | | |

| | |
|---|---|
| I The State where the aero-medical assessment is conducted:<br><br>III Cabin crew attestation reference number:<br><br>IV Last and first name:<br><br>XIV Date of birth (dd/mm/yyyy):<br><br>VI Nationality:<br><br>VII Signature of CCA applicant/holder: | II Aero-medical assessment result (fit/unfit):<br><br>Expiry date of the previous cabin crew medical report (dd/mm/yyyy):<br><br>Date of aero-medical assessment (dd/mm/yyyy):<br><br>X Date of issue* (dd/mm/yyyy):<br><br>X Signature of the AeMC, AME or OHMP:<br><br>XI Seal or stamp of the AeMC, AME or OHMP: |
| 2 | 3 |

* Date of issue is the date the Cabin Crew Medical Report is issued and signed.

| | |
|---|---|
| XII Limitation(s), if applicable:<br>Code:<br>Description:<br><br>Code:<br>Description:<br><br>Code:<br>Description: | IX Expiry date of this medical report (dd/mm/yyyy): |
| 4 | 5 |

## MED.C.035 Limitations

*Regulation (EU) No 1178/2011*

(a) If holders of a cabin crew attestation do not fully comply with the medical requirements specified in Section 2, the AME,AeMC or OHMP shall consider whether they may be able to perform cabin crew duties safely if complying with one or more limitations.

(b) Any limitation(s) to the exercise of the privileges granted by the cabin crew attestation shall be specified on the cabin crew medical report and shall only be removed by an AME,AeMC or by an OHMP in consultation with an AME.

# AMC1 MED.C.035 Limitations

ED Decision 2019/002/R

When assessing whether the holder of a cabin crew attestation may be able to perform cabin crew duties safely if complying with one or more limitations, the following possible limitations should be considered:

(a) a restriction to operate only in multi-cabin crew operations (MCL);

(b) a restriction to specified aircraft type(s) (OAL) or to a specified type of operation (OOL);

(c) a requirement to undergo the next aero-medical examination and assessment at an earlier date than required by MED.C.005(b) (TML);

(d) a requirement to undergo specific medical examination(s) (SIC);

(e) a requirement for visual correction (CVL), or by means of contact lenses that correct for defective vision (CCL);

(f) a requirement to use hearing aids (HAL); and

(g) special restriction as specified (SSL).

# SUBPART D – AERO-MEDICAL EXAMINERS (AME), GENERAL MEDICAL PRACTITIONERS (GMP), OCCUPATIONAL HEALTH MEDICAL PRACTITIONERS (OHMP)

## SECTION 1 – AERO-MEDICAL EXAMINERS

### MED.D.001 Privileges

*Regulation (EU) 2019/27*

(a) The privileges of holders of an aero-medical examiner (AME) certificate are to issue, revalidate and renew class 2 medical certificates and LAPL medical certificates and to conduct the relevant medical examinations and assessments.

(b) Holders of an AME certificate may apply for an extension of their privileges to include medical examinations for the revalidation and renewal of class 1 medical certificates, if they comply with the requirements set out in point MED.D.015.

(c) The privileges of a holder of an AME certificate referred to in points (a) and (b) shall include the privileges to conduct cabin crew members' aero-medical examinations and assessments and to provide the related cabin crew members' medical reports, as applicable, in accordance with this Annex (Part-MED).

(d) The scope of the privileges of the holder of an AME certificate, and any condition thereof, shall be specified in that certificate.

(e) A holder of an AME certificate shall not at any time hold more than one AME certificate issued in accordance with this Regulation.

(f) Holders of an AME certificate shall not undertake aero-medical examinations and assessments in a Member State other than the Member State that issued their AME certificate, unless they have completed all the following steps:

(1) they have been granted access by the other Member State concerned to exercise their professional activities as a specialised doctor;

(2) they have informed the competent authority of that other Member State of their intention to conduct aero-medical examinations and assessments and to issue medical certificates within the scope of their privileges as AME;

(3) they have received a briefing from the competent authority of that other Member State.

### MED.D.005 Application

*Regulation (EU) 2019/27*

(a) An application for an AME certificate or for an extension of the privileges of an AME certificate shall be made in a form and manner specified by the competent authority.

(b) Applicants for an AME certificate shall provide the competent authority with:

(1) their personal details and professional address;

(2) documentation demonstrating that they comply with the requirements of point MED.D.010, including evidence of successful completion of the training course in aviation medicine appropriate to the privileges they apply for;

(3) a written declaration that, once the AME certificate has been issued, the AME will issue medical certificates on the basis of the requirements of this Regulation.

(c) When AMEs undertake aero-medical examinations in more than one location, they shall provide the competent authority with relevant information regarding all practice locations and practice facilities.

## MED.D.010 Requirements for the issue of an AME certificate

*Regulation (EU) 2019/27*

Applicants shall be issued an AME certificate, where they meet all of the following conditions:

(a) they are fully qualified and licensed for the practice of medicine and have evidence of completion of specialist medical training;

(b) they have successfully completed a basic training course in aviation medicine, including practical training in the examination methods and aero-medical assessments;

(c) they have demonstrated to the competent authority that they:

(1) have adequate facilities, procedures, documentation and functioning equipment suitable for aero-medical examinations;

(2) have in place the necessary procedures and conditions to ensure medical confidentiality.

## MED.D.011 Privileges of an AME certificate holder

*Regulation (EU) 2019/27*

Through the issuance of an AME certificate, the holder shall be granted the privileges to initially issue, revalidate and renew all of the following:

(a) class 2 medical certificates;

(b) LAPL medical certificates;

(c) cabin crew members' medical reports.

## MED.D.015 Requirements for the extension of privileges

*Regulation (EU) 2019/27*

Applicants shall be issued an AME certificate extending their privileges to the revalidation and renewal of class 1 medical certificates where they meet all of the following conditions:

(a) they hold a valid AME certificate;

(b) they conducted at least 30 examinations for the issue, revalidation or renewal of class 2 medical certificates or equivalent over a period of no more than 3 years preceding the application;

(c) they successfully completed an advanced training course in aviation medicine, including practical training in the examination methods and aero-medical assessments;

(d) they have successfully completed practical training of a duration of at least 2 days, either at an AeMC or under the supervision of the competent authority.

## MED.D.020 Training courses in aviation medicine

*Regulation (EU) 2024/2076*

(a) Training courses in aviation medicine refered to in MED.D.010(b) and MED.D.015(c) shall only be provided after the prior approval of the course by the competent authority of the Member State where the training organisation has its principal place of business. In order to obtain such approval, the training organisation shall demonstrate that the course syllabus contains the learning objectives to acquire the necessary competencies and that the persons in charge of providing the training have adequate knowledge and experience.

(aa) For demonstrating compliance with points MED.D.010(b) and MED.D.015(c), an aviation medicine training course completed by an applicant outside the territories for which Member States are responsible under the Chicago Convention may be accepted by the competent authority, provided that the following conditions are met:

(i) the competent authority has assessed and verified the course syllabus in accordance with point ARA.MED.200(c)(1) of Annex VI;

(ii) the applicant has completed a specific training module on the aero-medical requirements detailed in this Annex (Part-MED) as provided by the competent authority.

*[applicable from 13 February 2025 - Regulation (EU) 2024/2076]*

(b) Except in the case of refresher training, the courses shall be concluded by a written examination on the subjects included in the course content.

(c) The training organisation shall issue a certificate of successful completion to participants when they have obtained a pass in the examination.

## AMC1 MED.D.020 Training courses in aviation medicine

*ED Decision 2019/002/R*

**BASIC TRAINING COURSE**

(a) Basic training course for AMEs

The basic training course for AMEs should consist of 60 hours of theoretical and practical training, including specific examination techniques.

(b) The learning objectives to acquire the necessary competencies should include theoretical knowledge, risk management, and decision-making principles in the following subjects. Demonstrations and practical skills should also be included, where appropriate.

(1) Introduction to aviation medicine;

(2) Basic aeronautical knowledge;

(3) Aviation physiology;

(4) Cardiovascular system;

(5) Respiratory system;

(6) Digestive system;

(7) Metabolic and endocrine systems;

(8) Haematology;

(9) Genitourinary system;

(10) Obstetrics and gynaecology;

(11) Musculoskeletal system;

(12) Psychiatry;

(13) Psychology;

(14) Neurology;

(15) Visual system and colour vision;

(16) Otorhinolaryngology;

(17) Oncology;

(18) Incidents and accidents escape and survival;

(19) Medication and flying;

(20) Legislation, rules and regulations;

(21) Cabin crew working environment;

(22) In-flight environment; and

(23) Space medicine.

## AMC2 MED.D.020 Training courses in aviation medicine

*ED Decision 2019/002/R*

**ADVANCED TRAINING COURSE**

(a) Advanced training course for AMEs

The advanced training course for AMEs should consist of 66 hours of theoretical and practical training, including specific examination techniques.

(b) The learning objectives to acquire the necessary competencies should include theoretical knowledge, risk management, and decision-making principles in the following subjects. Demonstrations and practical skills should also be included, where appropriate.

(1) Pilot working environment;

(2) Aerospace physiology;

(3) Clinical medicine;

(4) Cardiovascular system;

(5) Neurology;

(6) Psychiatry/psychology;

(7) Visual system and colour vision;

(8) Otorhinolaryngology;

(9) Dentistry;

(10) Human factors in aviation;

(11) Incidents and accidents, escape and survival; and

(12) Tropical medicine.

(c) Practical training in an AeMC should be under the guidance and supervision of the head of the AeMC.

(d) After the successful completion of the practical training, a report of demonstrated competency should be issued.

## GM1 MED.D.020 Training courses in aviation medicine

*ED Decision 2019/002/R*

**BASIC TRAINING COURSE**

| | | |
|---|---|---|
| (a) | Basic training course in aviation medicine | 60 hours |
| (1) | Introduction to aviation medicine | 2 hours |
| (i) | History of aviation medicine | |
| (ii) | Specific aspects of civil aviation medicine | |
| (iii) | Different types of recreational flying | |
| (iv) | AME and pilots relationship | |
| (v) | Responsibility of the AME in aviation safety | |
| (vi) | Communication and interview techniques | |
| (2) | Basic aeronautical knowledge | 2 hours |
| (i) | Flight mechanisms | |
| (ii) | Man-machine interface, informational processing | |
| (iii) | Propulsion | |
| (iv) | Conventional instruments, ‘glass cockpit’ | |
| (v) | Recreational flying | |
| (vi) | Simulator/aircraft experience | |
| (3) | Aviation physiology | 9 hours |
| (i) | Atmosphere | |
| (A) | Functional limits for humans in flight | |
| (B) | Divisions of the atmosphere | |
| (C) | Gas laws — physiological significance | |

(D) Physiological effects of decompression

(ii) Respiration

(A) Blood gas exchange

(B) Oxygen saturation

(iii) Hypoxia signs and symptoms

(A) Average time of useful consciousness (TUC)

(B) Hyperventilation signs and symptoms

(C) Barotrauma

(D) Decompression sickness

(iv) Acceleration

(A) G-Vector orientation

(B) Effects and limits of G-load

(C) Methods to increase Gz-tolerance

(D) Positive/negative acceleration

(E) Acceleration and the vestibular system

(v) Visual disorientation

(A) Sloping cloud deck

(B) Ground lights and stars confusion

(C) Visual autokinesis

(vi) Vestibular disorientation

(A) Anatomy of the inner ear

(B) Function of the semicircular canals

(C) Function of the otolith organs

(D) The oculogyral and coriolis illusion

(E) 'Leans'

(F) Forward acceleration illusion of 'nose up'

(G) Deceleration illusion of 'nose down'

(H) Motion sickness — causes and management

(vii) Noise and vibration

(A) Preventive measures

(4) Cardiovascular system 3 hours

(i) Relation to aviation; risk of incapacitation

(ii) Examination procedures: ECG, laboratory testing and other special examinations

(iii) Cardiovascular diseases:

(A) Hypertension, treatment and assessment

(B) Ischaemic heart disease

(C) ECG findings

(D) Assessment of satisfactory recovery from myocardial infarction, interventional procedures and surgery

(E) Cardiomyopathies; pericarditis; rheumatic heart disease; valvular diseases

(F) Rhythm and conduction disturbances, treatment and assessment

(G) Congenital heart disease: surgical treatment, assessment

(H) Cardiovascular syncope: single and repeated episodes

Topics (5) to (11) inclusive, and (17) 10 hours

(5) Respiratory system

(i) Relation to aviation, risk of incapacitation

(ii) Examination procedures: spirometry, peak flow, x-ray, other examinations

(iii) Pulmonary diseases: asthma, chronic obstructive pulmonary diseases

(iv) Infections, tuberculosis

(v) Bullae, pneumothorax

(vi) Obstructive sleep apnoea

(vii) Treatment and assessment

(6) Digestive system

(i) Relation to aviation, risk of incapacitation

(ii) Examination of the system

(iii) Gastro-intestinal disorders: gastritis, ulcer disease

(iv) Biliary tract disorders

(v) Hepatitis and pancreatitis

(vi) Inflammatory bowel disease, irritable colon/irritable bowel disease

(vii) Herniae

(viii) Treatment and assessment including post-abdominal surgery

(7) Metabolic and endocrine systems

(i) Relation to aviation, risk of incapacitation

(ii) Endocrine disorders

(iii) Diabetes mellitus Type 1 & 2

(A) Diagnostic tests and criteria

(B) Anti-diabetic therapy

(C) Operational aspects in aviation

(D) Satisfactory control criteria for aviation

(iv) Hyper/hypothyroidism

(v) Pituitary and adrenal glands disorders

(vi) Treatment and assessment

(8) Haematology

(i) Relation to aviation, risk of incapacitation

(ii) Blood donation aspects

(iii) Erythrocytosis; anaemia; leukaemia; lymphoma

(iv) Sickle cell disorders

(v) Platelet disorders

(vi) Haemoglobinopathies; geographical distribution; classification

(vii) Treatment and assessment

(9) Genitourinary system

(i) Relation to aviation, risk of incapacitation

(ii) Action to be taken after discovery of abnormalities in routine dipstick urinalysis, e.g. haematuria; albuminuria

(iii) Urinary system disorders:

(A) Nephritis; pyelonephritis; obstructive uropathies

(B) Tuberculosis

(C) Lithiasis: single episode; recurrence

(D) Nephrectomy, transplantation, other treatment and assessment

(10) Obstetrics and gynaecology

(i) Relation to aviation, risk of incapacitation

(ii) Pregnancy and aviation

(iii) Disorders, treatment and assessment

(11) Musculoskeletal system

(i) Vertebral column diseases

(ii) Arthropathies and arthroprosthesis

(iii) Pilots with a physical impairment

(iv) Treatment of musculoskeletal system, assessment for flying

(12) Psychiatry — 2 hours

- (i) Relation to aviation, risk of incapacitation
- (ii) Psychiatric examination
- (iii) Psychiatric disorders: neurosis; personality disorders; psychosis; organic mental illness
- (iv) Alcohol and other psychoactive substance(s) use
- (v) Treatment, rehabilitation and assessment

(13) Psychology — 2 hours

- (i) Introduction to psychology in aviation as a supplement to psychiatric assessment
- (ii) Methods of psychological examination
- (iii) Behaviour and personality
- (iv) Workload management and situational awareness
- (v) Flight motivation and suitability
- (vi) Group social factors
- (vii) Psychological stress, stress coping, fatigue
- (viii) Psychomotor functions and age
- (ix) Mental fitness and training

(14) Neurology — 3 hours

- (i) Relation to aviation, risk of incapacitation
- (ii) Examination procedures
- (iii) Neurological disorders
  - (A) Seizures — assessment of single episode
  - (B) Epilepsy
  - (C) Multiple sclerosis
  - (D) Head trauma
  - (E) Post-traumatic states
  - (F) Vascular diseases
  - (G) Tumours
  - (H) Disturbance of consciousness — assessment of single and repeated episodes
- (iv) Degenerative diseases
- (v) Sleep disorders
- (vi) Treatment and assessment

(15) Visual system and colour vision — 4 hours

- (i) Anatomy of the eye
- (ii) Relation to aviation duties
- (iii) Examination techniques
  - (A) Visual acuity assessment
  - (B) Visual aids
  - (C) Visual fields — acceptable limits for certification
  - (D) Ocular muscle balance
  - (E) Assessment of pathological eye conditions
  - (F) Glaucoma
- (iv) Monocularity and medical flight tests
- (v) Colour vision
- (vi) Methods of testing: pseudoisochromatic plates, lantern tests, anomaloscopy
- (vii) Importance of standardisation of tests and of test protocols
- (viii) Assessment after eye surgery

(16) Otorhinolaryngology — 3 hours

- (i) Anatomy of the systems
- (ii) Clinical examination in ORL
- (iii) Functional hearing tests
- (iv) Vestibular system; vertigo, examination techniques
- (v) Assessment after ENT surgery
- (vi) Barotrauma ears and sinuses
- (vii) Aeronautical ENT pathology
- (viii) ENT requirements

(17) Oncology

- (i) Relation to aviation, risk of metastasis and incapacitation
- (ii) Risk management
- (iii) Different methods of treatment and assessment

(18) Incidents and accidents, escape and survival — 1 hour

- (i) Accident statistics
- (ii) Injuries
- (iii) Aviation pathology, post-mortem examination, identification
- (iv) Aircraft evacuation

(A) Fire

(B) Ditching

(C) By parachute

(19) Medication and flying — 2 hours

(i) Hazards of medications

(ii) Common side effects; prescription medications; over-the-counter medications; herbal medications; 'alternative' therapies

(iii) Medication for sleep disturbance

(20) Legislation, rules and regulations — 4 hours

(i) ICAO Standards and Recommended Practices, European provisions (e.g. Implementing Rules, AMC and GM)

(ii) Incapacitation: acceptable aero-medical risk of incapacitation; types of incapacitation; operational aspects

(iii) Basic principles in assessment of fitness for aviation

(iv) Operational and environmental conditions

(v) Use of medical literature in assessing medical fitness; differences between scientific study populations and licensed populations

(vi) Flexibility

(vii) Annex 1 to the Chicago Convention, paragraph 1.2.4.9

(viii) Accredited Medical Conclusion; consideration of knowledge, skill and experience

(ix) Trained versus untrained crews; incapacitation training

(x) Medical flight tests

(21) Cabin crew working environment — 1 hour

(i) Cabin environment, workload, duty and rest time, fatigue risk management

(ii) Cabin crew safety duties and associated training

(iii) Types of aircraft and types of operations

(iv) Single-cabin crew and multi-cabin crew operations

(22) In-flight environment — 1 hour

(i) Hygiene aboard aircraft: water supply, oxygen supply, disposal of waste, cleaning, disinfection and disinsection

(ii) Catering

(iii) Crew nutrition

(iv) Aircraft and transmission of diseases

(23) Space medicine — 1 hour

(i) Microgravity and metabolism, life sciences

(24) Practical demonstrations of basic aeronautical knowledge 8 hours

(25) Concluding items 2 hours

(i) Final examination

(ii) De-briefing and critique

## GM2 MED.D.020 Training courses in aviation medicine

*ED Decision 2019/002/R*

**ADVANCED TRAINING COURSE**

(a) Advanced training course in aviation medicine 66 hours

(1) Pilot working environment 6 hours

(i) Commercial aircraft flight crew compartment

(ii) Business jets, commuter flights, cargo flights

(iii) Professional airline operations

(iv) Fixed wing and helicopter, specialised operations including aerial work

(v) Air traffic control

(vi) Single-pilot/multi-pilot

(vii) Exposure to radiation and other harmful agents

(2) Aerospace physiology 4 hours

(i) Brief review of basics in physiology (hypoxia, rapid/slow decompression, hyperventilation, acceleration, ejection, spatial disorientation)

(ii) Simulator sickness

(3) Clinical medicine 5 hours

(i) Complete physical examination

(ii) Review of basics with relationship to commercial flight operations

(iii) Class 1 requirements

(iv) Clinical cases

(v) Communication and interview techniques

(4) Cardiovascular system 4 hours

(i) Cardiovascular examination and review of basics

(ii) Class 1 requirements

(iii) Diagnostic steps in cardiovascular system

(iv) Clinical cases

(5) Neurology 3 hours

(i) Brief review of basics (neurological and psychiatric examination)

(ii) Alcohol and other psychoactive substance(s) use

(iii) Class 1 requirements

(iv) Clinical cases

(6) Psychiatry/psychology 5 hours

(i) Brief review of basics (psychiatric/psychological evaluation techniques)

(ii) Alcohol and other psychoactive substance(s) use

(iii) Class 1 requirements

(iv) Clinical cases

(7) Visual system and colour vision 5 hours

(i) Brief review of basics (visual acuity, refraction, colour vision, visual fields, night vision, stereopsis, monocularity)

(ii) Class 1 visual requirements

(iii) Implications of refractive and other eye surgery

(iv) Clinical cases

(8) Otorhinolaryngology 4 hours

(i) Brief review of basics (barotrauma — ears and sinuses, functional hearing tests)

(ii) Noise and its prevention

(iii) Vibration, kinetosis

(iv) Class 1 hearing requirements

(v) Clinical cases

(9) Dentistry 2 hours

(i) Oral examination including dental formula

(ii) Oral cavity, dental disorders and treatment, including implants, fillings, prosthesis, etc.

(iii) Barodontalgia

(iv) Clinical cases

(10) Human factors in aviation, including 8 hours demonstration and practical experience 22 hours

(i) Long-haul flight operations

(A) Flight time limitations

(B) Sleep disturbance

(C) Extended/expanded crew

(D) Jet lag/time zones

(ii) Human information processing and system design

(A) Flight Management System (FMS), Primary Flight Display (PFD), datalink, fly by wire

(B) Adaptation to the glass cockpit

(C) Crew Coordination Concept (CCC), Crew Resource Management (CRM), Line Oriented Flight Training (LOFT) etc.

(D) Practical simulator training

(E) Ergonomics

(iii) Crew commonality

(A) Flying under the same type rating, e.g. A-318, A-319, A-320, A-321

(iv) Human factors in aircraft incidents and accidents

(v) Flight safety strategies in commercial aviation

(vi) Fear and refusal of flying

(vii) Psychological selection criteria

(viii) Operational requirements (flight time limitation, fatigue risk management, etc.)

(11) Incidents and accidents, escape and survival — 2 hours

(i) Accident statistics

(ii) Types of injuries

(iii) Aviation pathology, post-mortem examination related to aircraft accidents, identification

(iv) Rescue and emergency evacuation

(12) Tropical medicine — 2 hours

(i) Endemicity of tropical disease

(ii) Infectious diseases (communicable diseases, sexually transmitted diseases, HIV etc.)

(iii) Vaccination of flight crew and passengers

(iv) Diseases transmitted by vectors

(v) Food and water-borne diseases

(vi) Parasitic diseases

(vii) International health regulations

(viii) Personal hygiene of aviation personnel

(13) Concluding items — 2 hours

(i) Final examination

(ii) De-briefing and critique

## GM3 MED.D.020 Training courses in aviation medicine

*ED Decision 2019/002/R*

**GENERAL**

(a) Principles of training:

To acquire knowledge and skills for the aero-medical examination and assessment, the training should be:

(1) based on regulations;

(2) based on general clinical skills and knowledge necessary to conduct relevant examinations for the different medical certificates;

(3) based on knowledge of the different risk assessments required for various types of medical certification;

(4) based on an understanding of the limits of the decision-making competences of an AME in assessing safety-critical medical conditions for when to defer and when to deny;

(5) based on knowledge of the aviation environment; and

(6) exemplified by clinical cases and practical demonstrations.

(b) Training outcomes:

The trainee should demonstrate a thorough understanding of:

(1) the aero-medical examination and assessment process:

(i) principles, requirements and methods;

(ii) ability to investigate all clinical aspects that present aero-medical risks, the reasonable use of additional investigations;

(iii) the role in the assessment of the ability of the pilot or cabin crew member to safely perform their duties in special cases, such as the medical flight test;

(iv) aero-medical decision-making based on risk management;

(v) medical confidentiality; and

(vi) correct use of appropriate forms, and the reporting and storing of information;

(2) the conditions under which the pilots and cabin crew carry out their duties; and

(3) principles of preventive medicine, including aero-medical advice in order to help prevent future limitations.

(c) The principles and training outcomes stated at (a) and (b) should also be taken into consideration for refresher training programmes

## MED.D.025 Changes to the AME certificate

*Regulation (EU) 2019/27*

(a) Holders of an AME certificate shall, without undue delay, notify the competent authority of the following circumstances which could affect their AME certificate:

(1) the AME is subject to disciplinary proceedings or investigation by a medical regulatory body;

(2) there are changes to the conditions under which the certificate was granted, including the content of the statements provided with the application;

(3) the requirements for the issuance of the AME certificate are no longer met;

(4) there is a change to the aero-medical examiner's practice location(s) or correspondence address.

(b) Failure to notify the competent authority in accordance with point (a) shall result in the suspension or revocation of the AME certificate in accordance with point ARA.MED.250 of Annex II (Part-ARA).

## MED.D.030 Validity of AME certificates

*Regulation (EU) 2019/27*

An AME certificate shall be valid for a period of 3 years, unless the competent authority decides to reduce that period for duly justified reasons related to the individual case.

Upon application by the holder, the certificate shall be:

(a) revalidated, provided that the holder:

(1) continues to fulfil the general conditions required for medical practice and maintains his or her licence for the practice of medicine;

(2) has undertaken refresher training in aviation medicine within the last 3 years;

(3) has performed at least 10 aero-medical examinations or equivalent every year;

(4) remains in compliance with the terms of the certificate;

(5) exercises the privileges in accordance with the requirements of this Annex (Part-MED);

(6) has demonstrated that he or she maintains his or her aero-medical competency in accordance with the procedure established by the competent authority.

(b) renewed, provided that the holder complies with either the requirements for revalidation set out in point (a) or with all of the following requirements:

(1) continues to fulfil the general conditions required for medical practice and maintains his or her licence for the practice of medicine;

(2) has undertaken refresher training in aviation medicine within the previous year;

(3) has successfully completed practical training within the previous year, either at an AeMC or under the supervision of the competent authority;

(4) remains in compliance with the requirements of point MED.D.010;

(5) has demonstrated that he or she maintains his or her aero-medical competency in accordance with the procedure established by the competent authority.

# AMC1 MED.D.030 Validity of AME certificates

*ED Decision 2019/002/R*

**REFRESHER TRAINING**

(a) It is the responsibility of the AME to continuously maintain and improve their competencies.

(b) During the period of validity of the AME certificate, an AME should attend a minimum of 20 hours of refresher training.

(c) An AME exercising class 1 privileges should attend at least 10 hours of refresher training per year.

(d) A proportionate number of refresher training hours should be provided by, or conducted under the direct supervision of, the competent authority or the medical assessor.

(e) The curricula of refresher training hours referred to in (c) should be decided by the competent authority following a risk-based assessment.

(f) Attendance at scientific meetings and congresses, and flight deck experience may be credited by the competent authority for a specified number of hours against the training obligations of the AME, provided the competent authority has assessed it in advance as being relevant for crediting purposes.

(g) In case of renewal of an AME certificate, the practical training should include at least 10 aero-medical assessments, in accordance with the type of the requested AME certificate.

# GM1 MED.D.030 Validity of AME certificates

*ED Decision 2019/002/R*

**REFRESHER TRAINING**

(a) The curricula for the refresher training hours that should be provided by, or conducted under the direct supervision of, the competent authority or the medical assessor may include but are not limited to subjects such as:

(1) Psychiatry

(i) Relation to aviation, risk of incapacitation;

(ii) Psychiatric examination;

(iii) Psychiatric disorders: neurosis, personality disorders, psychosis, organic mental illness;

(iv) Alcohol and other psychoactive substance(s) use; and

(v) Treatment, rehabilitation and assessment.

(2) Psychology

(i) Introduction to psychology in aviation as a supplement to psychiatric assessment;

(ii) Methods of psychological examination;

(iii) Behaviour and personality;

(iv) Workload management and situational awareness;

(v) Flight motivation and suitability;

(vi) Group social factors;

(vii) Psychological stress, stress coping, fatigue;

(viii) Psychomotor functions and age; and

(ix) Mental fitness and training.

(3) Communication and interview techniques

(b) Scientific meetings, congresses or flight deck experience that may be credited by the competent authority:

| | |
|---|---|
| International Academy of Aviation and Space Medicine Annual Congresses (ICASM) | 10 hours credit |
| European Conference of Aerospace Medicine (ECAM) | 10 hours credit |
| Aerospace Medical Association Annual Scientific Meetings (AsMA) | 10 hours credit |
| Other scientific meetings (A minimum of 6 hours to be under the direct supervision of the medical assessor of the competent authority) | 10 hours credit |

Flight crew compartment experience (a maximum of 5 hours credit per 3 years):

| | | |
|---|---|---|
| (i) | Jump seat | 5 sectors — 1 hour credit |
| (ii) | Simulator | 4 hours — 1 hour credit |
| (iii) | Aircraft piloting | 4 hours — 1 hour credit |

(c) An AME exercising class 1 revalidation/renewal privileges should attend international aviation medicine scientific meetings or congresses at regular intervals.

(d) Aero-medical examinations of military pilots may be considered as equivalent in accordance with MED.D.030(a)(3), subject to approval by the medical assessor of the competent authority.

## GM2 MED.D.030 Validity of AME certificates

*ED Decision 2019/002/R*

**AME PEER SUPPORT GROUPS**

(a) The competent authority should promote better performance of AMEs by supporting the establishment of AME peer support groups that could provide both professional support and educational enhancement.

(b) Attendance to AME peer support group meetings may be credited by the competent authority as refresher training. The competent authority should determine a maximum of hours that can be credited as refresher training during the period of authorisation.

(c) AME peer support groups may be established as part of, or complementary to, national associations of aerospace medicine.

# SECTION 2 – GENERAL MEDICAL PRACTITIONERS

## MED.D.035 Requirements for general medical practitioners

*Regulation (EU) 2019/27*

General medical practitioners (GMPs) may act as AMEs for issuing LAPL medical certificates, where they meet all of the following conditions:

(a) they exercise their activity in a Member State where GMPs have access to the full medical records of applicants;

(b) they exercise their activity in accordance with any additional requirements established in the national law of the Member State of their competent authority;

(c) they are fully qualified and licensed for the practice of medicine in accordance with national law of the Member State of their competent authority;

(d) they have notified the competent authority before starting such activity.

## SECTION 3 – OCCUPATIONAL HEALTH MEDICAL PRACTITIONERS

# MED.D.040 Requirements for occupational health medical practitioners

*Regulation (EU) 2019/27*

In Member States where the competent authority is satisfied that the requirements of the national health system applicable to occupational health medical practitioners (OHMPs) are such as to ensure compliance with the requirements of this Annex (Part-MED) applicable to OHMPs, OHMPs may conduct aero-medical assessments of cabin crew, provided that:

(a) they are fully qualified and licensed in the practice of medicine and qualified in occupational medicine;

(b) the in-flight working environment and safety duties of the cabin crew were included in their occupational medicine qualification syllabus or other training or operational experience;

(c) they have notified the competent authority before starting such activity.