

CONSENT BY APPLICANT

PATVIRTINTA Civilinės aviacijos administracijos direktoriaus 2015 m. balandžio 27 d. įsakymu Nr. 4R-74

14 priedas

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

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

I, (Name of applicant)consent to my aeromedical records being transferred between the Authority Medical Sections of the Licensing Authorities stated below and accept responsibility for any fees incurred in translating or transferring my records.						
Signature						
Please not Only Engl		ny charges incurred for translations are the	responsibility of the Applicant)			
ITEM	DESCRIPTION	THIS PAGE TO BE COMPLETED B	Y APPLICANT			
1	State of Transfer TO: Address:					
	Telephone:					
	Email:					
2	State of Transfer FROM: Address:					
	Telephone:					
	Email:					
3	Full name of holder					
4	Address of holder					
5	Date of Birth(dd/mm/yyyy)					
6	Nationality of holder					
7	Reference Number					
8	Licence(s) Held (e.g. ATPL/CPL/PPL)		Restrictions or Limitations (if any)			

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ITEM	MEDICAL HISTORY TO BE COMPLETED BY MEDICAL ASSESSOR OF TRANSFERRING AUTHORITY				
9	Any previous State(s) prior to current State (corecords have been hele	or where medical No	□ Yes □enclose details		
	Period of Medical Records Held (Dates From/To):				
	If there is insufficient space on this form for any information, please use additional pages.				
	Copies of the applicant's Aeromedical records should be enclosed with this form. The minimum documents required for transfer: Copy of earliest medical application and examination report forms All SOLI forms (and supporting documents) from previous transfers. Summary of medical history (see below) with supporting aeromedical assessments & clinical reports Copy of current medical application and examination report forms Copy of latest electrocardiogram (class 1 only) Copy of current medical certificate Summary of medical history (with dates) to include relevant inactive conditions and active conditions requiring follow-up				
VERIFICATION					
I (name)					
Further information/records are available on request					
Signature		Date: (dd/mm/yyyy)	Medical Assessor stamp		

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