**DAMO-Part-MED-008**

**MEDICAL IN CONFIDENCE**

**FORME PER TRANSFERIMIN E RECORDEVE MJEKSORE NDERMJET**

**SEKTOREVE MJEKSOR TE AUTORITETEVE LICENSUESE.**

*FORM FOR THE TRANSFER OF MEDICAL RECORDS BETWEEN MEDICAL*

*SECTIONS OF LICENSING AUTHORITIES.*

Lutemi ta plotesoni kete Forme me shkronja kapitale duke perdorur boje blu ose te zeze.

*Please complete the form in block capitals using black or blue ink.*

**CONSENT BY APPLICANT**

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

Signature........................................................................... Date...................................................................................

Please note:

Only Albanian/English Language accepted, any charges incurred for translations are the responsibility of the Applicant

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| **ITEM** | **DESCRIPTION** | **THIS PAGE TO BE COMPLETED BY 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  Telephone: Email: |  | |
| 5 | Date of Birth (dd/mm/yyyy) |  | |
| 6 | Nationality of holder |  | |
| 7 | Reference Number |  | |
| 8 | Licences held:  (e.g. ATPL/CPL/PPL) |  | Restrictions or limitations (if any) |
| **Document Checklist**  Please use this page to check you have fulfilled all the requirements before applying.  Please ensure that the consent section on the top of the SOLI (State of License Issue) form has been  completed and signed by the applicant.  The following documentation has been provided:   * Last application form for a medical certificate (official JAR or EASA form) Last medical examination report (official JAR or EASA form) * Last medical certificate (copy of front and back) (official JAR or EASA form) Last ECG * Last ophthalmological examination report (if applicable) (JAR or EASA) * Supporting aeromedical assessments and clinical reports relevant to the applicant’s medical history. * There are a number of common errors when requesting a *Transfer of Medical Records*. In order to complete a smooth application please ensure*:*    Summary of relevant medical history has been completed on the SOLI form;   Supporting aeromedical assessment and clinical reports are enclosed;   Aeromedical assessment/clinical reports have been translated into English;   The SOLI form has been signed, stamped and dated by a **Medical Assessor**;   Full contact details for the applicant are stated on the SOLI form, i.e. email address, current telephone number and postal address;   Confirmation of initial Class 1/2 examination date has been entered; | | | |

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| **ITEM** | **MEDICAL HISTORY TO BE COMPLETED BY MEDICAL ASSESSOR OF TRANSFERRING AUTHORITY** |
|  | Any previous State(s) of Licence Issue prior to current State Yes No enclose details  (or where medical records have been held)  Period of Medical Records Held 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 available 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 latest electrocardiogram (class 1 only)  • Copy of current medical certificate and supporting application and examination report forms.  Summary of medical history (with dates) to include relevant inactive conditions and active conditions requiring follow-up. |

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