

**Send to:**  
**postmottak@caa.no**  
**or**  
**Luftfartstilsynet**  
**Postboks 243**  
**8001 BODØ**

## Application for approval as an Aeromedical Examiner

Personal information	
Surname, First name:	
Nationality:	Country of residence:
License number (if applicable):	AME-number (if applicable):
Telephone number:	E-mail:

Application	
<input type="checkbox"/> Initial application	<input type="checkbox"/> Class 1
<input type="checkbox"/> Application for revalidation of a still valid AME-certificate	<input type="checkbox"/> Class 2
<input type="checkbox"/> Application for renewal (previously expired AME-certificate)	<input type="checkbox"/> Class 3

Address for aeromedical practice (may be published on the CAA's website)		
Name of medical center/place of business:		
Street address:	Zip code:	City:
Country:		
Phone:	Fax:	
<input type="checkbox"/> A different address is used for invoice (send as attachment)	<input type="checkbox"/> The aeromedical practice will be performed at several addresses (send as attachment)	

Medical degree and specialty*		
M.D (year):	University:	
Country:	Medical speciality:	Date of approval as specialist:

AME course *			
<input type="checkbox"/> Basic AME course or equivalent	Name of course:	Place:	Date:
<input type="checkbox"/> Advanced AME course or equivalent	Name of course:	Place:	Date:

Number of aeromedical examinations during the last 3 years			
	Year:	Year:	Year:
Class 1			
Class 2			
Class 3			
LAPL			
Cabin Crew			
Other (Please specify):			

Continuing aeromedical education or other relevant experience since previous application or during the last 3 years (the latter does not apply for initial application) *		
Course/congress/other aeromedical experience:	Location and date:	No of hours:

Signature	
I will at all times during the approval period stay updated on current regulations and procedures for aeromedical certification and follow these in my work as an AME.	
Date, place:	Signature: