

DAYTON CHEST MEDICINE

PULMONARY AND AEROSPACE MEDICINE
FAA CERTIFIED AVIATION MEDICAL EXAMINERS

Date:

Name:

DOB:

Date of last FAA exam:

Class:

**Do you, or did you, have
a Special Issuance from
the FAA?**

Yes ____ No ____

If yes, for what medical condition(s) was the SI?

**Medical conditions you
are currently being
treated for:**

**Medications you
currently take:**

Date of first BasicMed:

**Date of most
recent CMEC:**

**Family
Physician:**

**Specialists/
Specialty:**