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Dr. Peterson is now providing **TELEMEDICINE** and **IN-PERSON**

Transport Canada Aviation Medical Examinations

at Suite 201 - 481 London Road, Sarnia, Ontario N7T 4X3

Easiest way to book is on-line at: **drpeterson.ca/avmed**

Alternatively, feel free to text us at **519-328-0563**

or e-mail us at **info@drpeterson.ca**

We offer three products:

1)	**Urgent** (within 1 hour & after-hours) TeleMedicine Renewal Assessment	$499
2)	Routine TeleMedicine Renewal Assessment	$199
3)	Routine In-Office FULL Examination & Assessment	$249
	(If an ECG is required, it will be completed during examination)	$ 40

** Complex medical chart review requiring more than 15 minutes of time will be billed at $500 per hour in increments of 0.1 hour (rarely charged)
** We accept credit cards, debit cards, and cash
** All services have HST in addition

Transport Canada Aviation Medicine Examination

Existing Applicant Privacy Notice

Privacy Notice

Collection and use of personal information is in accordance with the *Privacy Act*. This personal information is required and used for the purposes of establishing medical fitness of civil aviation licence holders for the issuance or revalidation of medical certificates that validate personal aviation licences. This information is collected in accordance with the *Aeronautics Act*, pursuant to sections 404 and 424 of the *Canadian Aviation Regulations*.

Personal information will be protected under the provisions of the *Privacy Act* and is described in Personal Information Bank "Civil Aviation Medical Assessments TC PPU 020" which is detailed in TC *Info Source* Chapter at http://www.tc.gc.ca/. Information may be disclosed to the Transportation Appeal Tribunal of Canada as part of its review of licensing decisions; and to the Transportation Safety Board for the purpose of safety investigations. Information may also be used or disclosed for audit, evaluation, and reporting to senior management. The information is retained until the individual reaches 100 years of age or 15 years after the department is notified that the person is deceased. After the retention period expires, the information will be destroyed.

The *Privacy Act* states that you have the right to access your personal information and to request changes to incorrect information. For more information about this Privacy Notice Statement, please contact Civil Aviation Medicine by email: AviationMedicine-Medecineaeronautique@tc.gc.ca.

Privacy Consent

By providing your personal information, you acknowledge that you have read and understood this statement and consent to the Department's collection, use and disclosure of your personal information for the purposes as outlined above.

Applicant Name	Applicant Signature	Date

Transport Canada Transports Canada

PROTECTED "B" WHEN COMPLETED

CIVIL AVIATION MEDICAL EXAMINATION REPORT

PART A

Has the applicants mailing address changed since their last medical? ◯ Yes ◯ No

Type of medical category desired	Aviation medical category held	Permit or Licence number 5802-
Given Names	Family Name	Former Surname

Home Address (Number, street, apartment)

City	Province	Country	Postal Code

Is the home address the same as the mailing address? ◯ Yes ◯ No (if no, provide details)

Mailing Address (Number, street, apartment)

City	Province	Country	Postal Code

Telephone number (999-999-9999)	Business telephone (999-999-9999)	Cell number (999-999-9999)	E-mail
Date of Birth (yyyy-mm-dd)	Sex ◯ Male ◯ Female	Citizenship	Language of correspondence ◯ English ◯ French

Employer	Education

Has the applicant undergone a practical flight test to assess medical fitness to fly? Example: Cockpit assessment due to hearing loss.

◯ No ◯ Yes (if yes, provide details)

Aircraft/vehicle accident since last exam?

◯ Yes ◯ No

Pilot flying time last 12 months	Pilot total flying time

Refusal of issue or renewal of medical certificate?

◯ Yes ◯ No

Has the applicant consulted a physician or other health care provider since their last aviation medical? ◯ No ◯ Yes (if yes, provide details)

Is the applicant in receipt of a pension or other compensation for injury? ◯ No ◯ Yes (if yes, please list all associated medical conditions)

Entered in CAMIS ______________

Canada

Name	Permit or Licence number	Date of Birth (yyyy-mm-dd)	Date of examination (yyyy-mm-dd)
	5802-		

PART B (To be completed by examiner)

REVIEW OF SYSTEMS

Has the applicant ever had or been treated for any of the following conditions?

Condition	Yes	No
1. Head injury, dizziness, loss of consciousness	◯ Yes	◯ No
2. Neurological problems, epilepsy, seizures	◯ Yes	◯ No
3. Ear disease or deafness	◯ Yes	◯ No
4. Gastrointestinal disorders	◯ Yes	◯ No
5. Genito-urinary disorders	◯ Yes	◯ No
6. Alcohol or substance abuse, impaired driving events	◯ Yes	◯ No
7. Frequent or severe headaches, migraines	◯ Yes	◯ No
8. Psychiatric, anxiety, depression, ADHD	◯ Yes	◯ No
9. Pulmonary disorders including asthma, COPD, OSA	◯ Yes	◯ No
10. Cardiovascular disorders, hypertension, coronary artery disease, arrhythmia	◯ Yes	◯ No
11. Musculo - skeletal disorders	◯ Yes	◯ No
12. Allergies	◯ Yes	◯ No
13. Menstrual Issues	◯ Yes	◯ No
14. Vision or eye problems including refractive surgery, cataract surgery, orthokeratology, or intraocular lens implants	◯ Yes	◯ No
15. Diabetes	◯ Yes	◯ No
16. Cancer	◯ Yes	◯ No
17. Any other medical conditions	◯ Yes	◯ No

Does the applicant have a significant family history of ischemic heart disease (first degree relative with an event before age 55 (if male) or 60 (if female) ?

◯ Yes ◯ No

Please Elaborate on all positive responses above; List relevant family history, past surgical history, and serious illnesses (additional space is available on page 3).

In the past twelve months has the applicant:

1. Used ANY medication to treat a medical condition? (This includes prescription, non-prescription, over-the-counter, herbal medications, cannabis, or cannabis-derived products. *Examples: acetaminophen for backpain, cannabis for anxiety, cannabidiol (CBD) for chronic pain)* ◯ Yes ◯ No

(If yes, please list medication name, dose, and route of administration, frequency, and reason for use)

2. Used tobacco or any product containing nicotine? This includes cigarettes, vaping devices, gum, hookah, cigars, or nicotine patches? ◯ Yes ◯ No

(If yes, please list Product name or type, dose, route of administration, and frequency)

3. Used alcohol? (If yes, average units per week): ______________ ◯ Yes ◯ No

4. Used Cannabis or cannabis derived product for non-medical purposes? ◯ Yes ◯ No

5. Used any other drug or substance (excluding cannabis and alcohol), for recreational or non-medical purposes? ◯ Yes ◯ No

(If yes, please list)

Additional Comments

Canada