UNITED STATES COAST GUARD AUXILIARY AVIATION PROGRAM

FLIGHT CREW MEDICAL SCREENING FORM

Date of Examination__________________

Applicant Name______________________________________________________________

Auxiliary Number_____________________

DOB__________________________

AFTER COMPLETION OF THE MEDICAL SCREENING PLEASE FORWARD THE COMPLETED FORM AS DIRECTED

Note to the physician:

This member of the US Coast Guard Auxiliary has come to you for an evaluation of basic health and condition, with specific information sought in certain areas which have a direct applicability to the member’s potential performance and safety during the conduct of missions.

In addition to the data requested on the form, your judgment is sought regarding the member’s ability to tolerate long flights (3 to 5 hours duration) in small aircraft and their ability to successfully egress from the aircraft and swim to a raft in the event of an emergency. Members must be capable of completing an annual drill in which they must swim 75 yards fully clothed and then climb into a raft.
Section 1 - Examination

Please examine the member in each category below and circle the appropriate answer. For any “No” answers in this section, please explain (on the reverse of this form if necessary) why that condition should not disqualify the member from participating in the program.

**Distant Vision** – 20/40 or better in each eye with or without correction -  
Yes / No

**Near Vision** - 20/40 or better in each eye at 16 inches --  
Yes / No

**Color Vision** - Able to discern Red, Green, & Yellow -  
Yes / No

**Hearing** - Hearing average conversational voice in a quiet room  
Using both ears at 6 feet, with the back tuned to the examiner -  
Yes / No

Or -- Pass the audiometric test below.

**Audiometry** - Pure tone audiometric test: Unaided, no worse than:

<table>
<thead>
<tr>
<th></th>
<th>500 HZ</th>
<th>1000 HZ</th>
<th>2,000 HZ</th>
<th>3,000 HZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Ear</td>
<td>35 Db</td>
<td>30 Db</td>
<td>30 Db</td>
<td>40 Db</td>
</tr>
<tr>
<td>Worst Ear</td>
<td>35 Db</td>
<td>50 Db</td>
<td>50 Db</td>
<td>60 Db</td>
</tr>
</tbody>
</table>

Yes / No

**ENT** - Absence of any ear condition manifested by vertigo or a disturbance of speech or equilibrium. -  
Yes / No

**Pulse** - Normal -  
Yes / No

**Blood Pressure** - Not over 155/95 with___ or without ___ medication  
Medication(s):___________________________________  
Yes / No

**Mental** - Absence of psychosis, bipolar disorder, or severe personality disorders -  
Yes / No

**Substance Dependence and Substance Abuse** – Absence of a diagnosis of substance dependence or established evidence of recovery, including total abstinence from the substance(s) for not less than the preceding 2 years. (“Substance” includes, PCP, sedatives, hypnotics, anxiolytics, marijuana, cocaine, opioids, amphetamines, hallucinogens, and other psychoactive drugs or chemicals.)  
Yes / No
Section 2 – Medical History

Medical History Requiring Explanation - For any “Yes” answers in this section, please explain (on the reverse of this form if necessary) why that condition should not disqualify the member from participating in the program.

History of:

1. Diabetes Mellitus requiring medication - Yes / No
2. Angina Pectoris - Yes / No
3. Coronary heart disease being treated, is symptomatic or clinically significant. - Yes / No
4. Myocardial Infarction - Yes / No
5. Cardiac Valve Replacement - Yes / No
6. Permanent Cardiac Pacemaker - Yes / No
7. Heart Replacement - Yes / No
8. Epilepsy - Yes / No
9. Disturbance of Consciousness - (without satisfactory explanation of cause) Yes / No
10. Transient Loss of Control of Nervous System Functions - (without satisfactory explanation of cause) Yes / No

Additional comments:
Coast Guard Auxiliary
Flight Crew Medical Screening

Your signature on this form indicates your judgment that this member is capable of participating in the program as described above without undue risk to themselves and/or others due to their medical history and condition.

Please sign the form attesting to your findings and return the completed form to the examinee.

Signed  _____________________________________ M.D./ D.O.

Name  _______________________________________

Address  ____________________________________

__________________________________________

Phone  _____________________________________

Additional comments: