**ACCEPTALE MEANS OF COMPLIANCE (AMC)**

**&**

**GUIDANCE MATERIEL (GM)**

**ANNEX IV**

**(PARTIE MED)**

**LICENCES DES MEMBRES D’ÉQUIPAGES DE CONDUITE**

**AMC/GM - PARTIE MED**

**LISTE DES PAGES EFFECTIVES**

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| Regulation (CEMAC) No N°XXX/CEMAC/PC/DAJ XXXX/2022) | EU | Acceptable Means of Compliance (AMC) and Guidance Material (GM) to Annex I (PART-M) | N° 2 | 20/07/2022 |
| Regulation (CEMAC) No N°XXX/CEMAC/PC/DAJ XXXX/2022) | EU | Easy Access Rules for Continuing Airworthiness (Regulation | N° 1 | 20/07/2022 |
| Regulation (CEMAC) No N°XXX/CEMAC/PC/DAJ XXXX/2022) | EU | Acceptable Means of Compliance (AMC) and Guidance Material (GM) to Annex I (PART-M) | Issue 2 Amendment 3 | 20/07/2022 |
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**SUBPART A – GENERAL**

**REQUIREMENTS SECTION 1 – GENERAL**

**AMC1 MED.A.015 Medical confidentiality** ED Decision 2022/0X/R

To ensure medical confidentiality, all medical reports and records should be securely held with accessibility restricted to personnel authorised by the medical assessor or, where applicable, by the head of the aero-medical centre (AEMC), the aero-medical examiner (AME), general medical practitioner (GMP)

**GM1 MED.A.020 Decrease in medical fitness** ED Decision 2019/002/R

**MEDICATION – GUIDANCE FOR PILOTS AND CABIN CREW MEMBERS**

 (a) Any medication can cause side effects, some of which may impair the safe performance of flying duties. Equally, symptoms of colds, sore throats, diarrhoea and other abdominal upsets may cause little or no problem whilst on the ground but may distract the pilot or cabin crew member and degrade their performance whilst on duty. The in-flight environment may also increase the severity of symptoms which may only be minor whilst on the ground. Therefore, one issue with medication and flying is the underlying condition and, in addition, the symptoms may be compounded by the side effects of the medication prescribed or bought over the counter for treatment. This guidance material provides some help to pilots and cabin crew in deciding whether expert aero-medical advice by an AME, AeMC, GMP or medical assessor is needed.

 (b) Before taking any medication and acting as a pilot or cabin crew member, the following three basic questions should be satisfactorily answered:

 (1) Do I feel fit to fly?

(2) Do I really need to take medication at all?

(3) Have I given this particular medication a personal trial on the ground to ensure that it will not have any adverse effects on my ability to fly?

 (c) Confirming the absence of adverse effects may well need expert aero-medical advice.

(d) The following are some widely used medicines with a description of their compatibility with flying duties:

(1) Antibiotics. Antibiotics may have short-term or delayed side effects which can affect pilot or cabin crew performance. More significantly, however, their use usually indicates that an infection is present and, thus, the effects of this infection may mean that a pilot or cabin crew member is not fit to fly and should obtain expert aero-medical advice.

 (2) Anti-malaria drugs. The decision on the need for anti-malaria drugs depends on the geographical areas to be visited, and the risk that the pilot or cabin crew member has of being exposed to mosquitoes and of developing malaria. An expert medical opinion should be obtained to establish whether anti-malaria drugs are needed and what kind of drugs should be used. Most of the anti-malaria drugs (atovaquone plus proguanil, chloroquine, doxycycline) are compatible with flying duties. However, adverse effects associated with mefloquine include insomnia, strange dreams, mood changes, nausea, diarrhoea and headaches. In addition, mefloquine may cause spatial disorientation and lack of fine coordination and is, therefore, not compatible with flying duties.

3) Antihistamines. Antihistamines can cause drowsiness. They are widely used in ‘cold cures’ and in treatment of hay fever, asthma and allergic rashes. They may be in tablet form or a constituent of nose drops or sprays. In many cases, the condition itself may preclude flying, so that, if treatment is necessary, expert aero-medical advice should be sought so that so-called non-sedative antihistamines, which do not degrade human performance, can be prescribed.

(4) Cough medicines. Antitussives often contain codeine, dextromethorfan or pseudoephedrine which are not compatible with flying duties. However, mucolytic agents (e.g. carbocysteine) are well-tolerated and are compatible with flying duties.

(5) Decongestants. Nasal decongestants with no effect on alertness may be compatible with flying duties. However, as the underlying condition requiring the use of decongestants may be incompatible with flying duties, expert aero-medical advice should be sought. For example, oedema of the mucosal membranes causes difficulties in equalising the pressure in the ears or sinuses.

(6) Nasal corticosteroids are commonly used to treat hay fever, and they are compatible with flying duties.

(7) (i) Common pain killers and antifebrile drugs. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and paracetamol, commonly used to treat pain, fever or headaches, may be compatible with flying duties. However, the pilot or cabin crew

member should give affirmative answers to the three basic questions listed in (b) before using the medication and carrying out flying duties. (ii) Strong analgesics. The more potent analgesics including codeine are opiate derivatives, and may produce a significant decrement in human performance and, therefore, are not compatible with flying duties

(8) Anti-ulcer medicines. Gastric secretion inhibitors such as H2 antagonists (e.g. ranitidine, cimetidine) or proton pump inhibitors (e.g. omeprazole) may be acceptable after diagnosis of the pathological condition. It is important to seek for the medical diagnosis and not to only treat the dyspeptic symptoms.

 (9) Anti-diarrhoeal drugs. Loperamide is one of the more common anti-diarrhoeal drugs and is usually safe to take whilst flying. However, the diarrhoea itself often makes the pilot and cabin crew member unfit for flying duties.

 (10) Hormonal contraceptives and hormone replacement therapy usually have no adverse effects and are compatible with flying duties.

(11) Erectile dysfunction medication. This medication may cause disturbances in colour vision and dizziness. There should be at least 6 hours between taking sildenafil and flying duty; and 36 hours between taking vardenafil or tadalafil and flying duty.

(12) Smoking cessation. Nicotine replacement therapy may be acceptable. However, other medication affecting the central nervous system (buproprion, varenicline) is not acceptable for pilots.

 (13) High blood pressure medication. Most anti-hypertensive drugs are compatible with flying duties However, if the level of blood pressure is such that drug therapy is required, the pilot or cabin crew member should be monitored for any side effects before carrying out flying duties. Therefore, consultation with the AME, AeMC, GMP, OHMP or medical assessor as applicable, is needed.

(14) Asthma medication. Asthma has to be clinically stable before a pilot or cabin crew member can return to flying duties. The use of respiratory aerosols or powders, such as corticosteroids, beta-2-agonists or chromoglycic acid may be compatible with flying duties. However, the use of oral steroids or theophylline derivatives is incompatible with flying duty. Pilots or cabin crew members using medication for asthma should consult the AME, AeMC, GMP, OHMP or medical assessor, as applicable.

(15) Tranquillisers and sedatives. The inability to react, due to the use of this group of medicines, has been a contributory cause to fatal aircraft accidents. In addition, the underlying condition for which these medications have been prescribed will almost certainly mean that the mental state of a pilot or cabin crew member is not compatible with flying duties.

(16) Sleeping tablets. Sleeping tablets dull the senses, may cause confusion and slow reaction times. The duration of effect may vary from individual to individual and may be unduly prolonged. Expert aero-medical advice should be obtained before using sleeping tablets.

(17) Melatonin. Melatonin is a hormone that is involved with the regulation of the circadian rhythm. In some countries it is a prescription medicine, whereas in most other countries it is regarded as a ‘dietary supplement’ and can be bought without any prescription. The results from the efficiency of melatonin in treatment of jet lag or sleep disorders have been contradictory. Expert aero-medical advice should be obtained.

 (18) Coffee and other caffeinated drinks may be acceptable, but excessive coffee drinking may have harmful effects, including disturbance of the heart’s rhythm. Other stimulants including caffeine pills, amphetamines, etc. (often known as ‘pep’ pills) used to maintain wakefulness or suppress appetite can be habit forming. Susceptibility to different stimulants varies from one individual to another, and all may cause dangerous overconfidence. Overdosage causes headaches, dizziness and mental disturbance. These other stimulants should not be used.

 (19) Anaesthetics. Following local, general, dental and other anaesthetics, a period of time should elapse before returning to flying. The period will vary considerably from individual to individual, but a pilot or cabin crew member should not fly for at least 12 hours after a local anaesthetic, and for at least 48 hours after a general, spinal or epidural anaesthetic (see MED.A.020).

(e) Many preparations on the market nowadays contain a combination of medicines. It is, therefore, essential that if there is any new medication or dosage, however slight, the effect should be observed by the pilot or the cabin crew member on the ground prior to flying. It should be noted that medication which would not normally affect pilot or cabin crew performance may do so in individuals who are ‘oversensitive’ to a particular preparation. Individuals are, therefore, advised not to take any medicines before or during flight unless they are completely familiar with their effects on their own bodies. In cases of doubt, pilots and cabin crew members should consult an AME, AeMC, GMP, OHMP or medical assessor, as applicable.

(f) Other treatments Alternative or complementary medicine, such as acupuncture, homeopathy, hypnotherapy and several other disciplines, is developing and gaining greater credibility. Such treatments are more acceptable in some States than others. There is a need to ensure that ‘other treatments’, as well as the underlying condition, are declared and con sidered by the AME, AeMC, GMP, OHMP or medical assessor, as applicable, for assessing fitness.

**AMC1 MED.A.025 Obligations of the AeMC, AME, GMP and OHMP**

ED Decision 2019/002/R

(a) If the medical examination is carried out by two or more AMEs or GMPs, only one of them should be responsible for coordinating the results of the examination, evaluating the findings with regard to medical fitness, and signing the report.

(b) The applicant should be made aware that the associated medical certificate or cabin crew report may be suspended or revoked if the applicant provides incomplete, inaccurate or false statements on their medical history to the AeMC, AME, GMP or OHMP.

(c) In cases where the AeMC or AME is required to assess the fitness of an applicant for a class 2 medical certificate in consultation with the medical assessor of the licensing authority, they should document the consultation in accordance with the procedure established by the competent authority.

 (d) The AeMC, AME, GMP or OHMP should give advice to the applicant on treatment and preventive measures if, during the course of the examination, medical conditions or risk factors are identified which may endanger the medical fitness of the applicant in the future. (e) When data is not being properly recorded in the European aero-medical data repository (EAMR due to unserviceability of the system, the AeMCs and AMEs should enter, or correct the existing data, in the EAMR without undue delay when the system recovers.

 (f) In case of denial or referral to the licensing authority, the AeMC, AME, GMP or OHMP should inform the applicant in writing regarding the result of the assessment in a form and manner established by the competent authority.

**GM1 MED.A.025 Obligations of the AeMC, AME,**

ED Decision 2019/002/R

GUIDELINES FOR THE AeMC, AME OR GMP CONDUCTING THE MEDICAL EXAMINATIONS AND ASSESSMENTS FOR MEDICAL CERTIFICATION OF PILOTS

(a) Before performing the medical examination, the AeMC, AME or GMP should:

(1) verify the applicant’s identity by checking their identity card, passport, driving licence or other official document containing a photograph of the applicant;

(2) obtain details of the applicant’s flight crew licence from the applicant’s licensing authority if they do not have their licence with them;

(3) except for initial applicants, obtain details of the applicant’s most recent medical certificate from the medical assessor of the applicant’s licensing authority if they do not have their certificate with them;

(4) in the case of a specific medical examination(s) (SIC) limitation on the existing medical certificate, obtain details of the specific medical condition and any associated instructions from the medical assessor of the applicant’s licensing authority. This could include, for example, a requirement to undergo a specific examination or test;

(5) except for initial applicants, ascertain, from the previous medical certificate, which routine medical test(s) should be conducted, for example electrocardiography (ECG);

(6) provide the applicant with the application form for a medical certificate and the instructions for completion and ask the applicant to complete the form but not to sign it yet;

(7) go through the form with the applicant and give information to help the applicant understand the significance of the entries and ask any questions which might help the applicant to recall important historical medical data;

(8) verify that the form is complete and legible, ask the applicant to sign and date the form and then sign it as well. If the applicant declines to complete the application form fully, inform the applicant that it may not be possible to issue a medical certificate regardless of the outcome of the clinical examination and assessment.

(b) Once all the items in (a) have been addressed, the AeMC, AME o should:

(1) perform the medical examination of the applicant in accordance with the applicable rules;

 (2) arrange for additional specialist medical examinations, such as otorhinolaryngology (ENT) or ophthalmology, to be conducted as applicable and obtain the associated report forms or reports;

(3) complete the medical examination report form in accordance with the associated instructions for completion;

 (4) ensure that all of the report forms are complete, accurate and legible.

(c) Once all the actions in (b) have been carried out, the AeMC, AME o should review the report forms and:

(1) if satisfied that the applicant meets the applicable medical requirements as set out in Part-MED, issue a medical certificate for the appropriate class, with limitations if necessary. The applicant should sign the certificate once signed by the AeMC, AME or GMP; or

 (2) if the applicant does not meet the applicable medical requirements, or if the fitness of the applicant for the class of medical certificate applied for is in doubt: (i) refer the decision on medical fitness to, or consult the decision on medical fitness with, the medical assessor of the licensing authority or AME in compliance with MED.B.001; or (ii) deny issuance of a medical certificate, explain the reason(s) for denial to the applicant and inform them of their right of a review according to the procedures of the competent authority.

 (d) The AeMC, AME or GMP should send the documents as required by MED.A.025(b) to the medical assessor of the applicant’s licensing authority within 5 days from the date of the medical examination. If a medical certificate has been denied or the decision has been referred, the documents should be sent to the medical assessor of the licensing authority on the same day that the denial or referral decision is reached

**SECTION 2 - REQUIREMENTS FOR MEDICAL CERTIFICATES**

**MED.A.030 Medical certificate**

**AMC1 MED.A.030 Medical certificates**

ED Decision 2022/XXX/XX

1. A class 1 medical certificate includes the privileges and validities of class 2 and LAPL medical certificates. (b) A class 2 medical certificate includes the privileges and validities of a LAPL medical certificate.

**MED.A.035 Application for a medical certificate**

**AMC1 MED.A.035** Application for a medical certificate

ED Decision 2019/002/R

Except for initial applicants, the AeMC, AME should not start the aero-medical examination for the issue of the medical certificate where applicants do not present the most recent medical certificate, unless relevant information is received from the medical assessor of the licensing authority.

**SUBPART B – REQUIREMENTS FOR PILOT MEDICAL CERTIFICATES**

**SECTION 1 – GENERAL**

**MED.B.001 Limitations to medical certificates**

**AMC1 MED.B.001 Limitations to medical certificates**

ED Decision 2019/002/R

**GENERAL**

 (a) An AeMC or AME may refer the decision on fitness of an applicant to the medical assessor of the licensing authority in borderline cases or where fitness is in doubt.

(b) In cases where a fit assessment may only be considered with a limitation, the AeMC, AME, GMP or the medical assessor of the licensing authority should evaluate the medical condition of the applicant in consultation with flight operations and other experts, if necessary.

(c) Initial application of limitations

(1) The limitations TML, VDL, VML, VNL and VCL, as listed in AMC2 MED.B.001(a), may be imposed by an AME or an AeMC for class 1, class 2, and LAPL medical certificates, or a GMP for LAPL medical certificates.

(2) All other limitations listed in AMC2 MED.B.001(a) should only be imposed: (i) for class 1 medical certificates, by the medical assessor of the licensing authority where a referral is required according to MED.B.001; (ii) for class 2 medical certificates, by the AME or AeMC in consultation with the medical assessor of the licensing authority where consultation is required according to MED.B.001; (iii) for LAPL medical certificates, by an AME or AeMC.

(d) Removal of limitations

(1) For class 1 medical certificates, all limitations should only be removed by the medical assessor of the licensing authority.

(2) For class 2 medical certificates, limitations may be removed by the medical assessor of the licensing authority or by an AeMC or AME in consultation with the medical assessor of the licensing authority.

(3) For LAPL medical certificates, limitations may be removed by an AeMC or AME.

**AMC2 MED.B.001 Limitations to medical certificates**

ED Decision 2019/002/R

**LIMITATION CODES**

(a) The following abbreviations for limitations codes should be used on the medical certificates as applicable:

|  |  |
| --- | --- |
| Code  |  Limitation |
| TML  |  Limited period of validity of the medical certificate |
| VDL  |  Valid only with correction for defective distant vision |
| VML  |  Valid only with correction for defective distant, intermediate and near vision |
| VNL  |  Valid only with correction for defective near vision |
| CCL  |  Correction by means of contact lenses |
| VCL  |  Valid by day only |
| RXO | Specialist ophthalmological examination(s) |
|  |  |
| SIC  |  Specific medical examination(s) |
| HAL  |  Valid only when hearing aids are worn |
| APL  |  Valid only with approved prosthesis |
| AHL  |  Valid only with approved hand controls |
| OML |  Valid only as, or with, a qualified co-pilot |
| OCL  |  Valid only as a qualified co-pilot |
| OSL  |  Valid only with a safety pilot and in aircraft with dual controls |
| OPL  | Valid only without passengers |
| ORL  | ORL Valid only with a safety pilot if passengers |
| OAL | OAL Restricted to demonstrated aircraft type |
| SSL  | SSL Special restriction(s) as specified |

(b) The abbreviations for the limitation codes should be explained to the holder of a medical certificate as follows:

(1) TML Time limitation

The period of validity of the medical certificate is limited to the duration as shown on the medical certificate. This period of validity commences on the date of the medical examination. Any period of validity remaining on the previous medical certificate is no longer valid. The holder of the medical certificate should present themselvs for re examination when advised and should follow any medical recommendations.

(2) VDL Wear corrective lenses and carry a spare set of spectacles

Correction for defective distant vision: whilst exercising the privileges of the licence, the holder of the medical certificate should wear spectacles or contact lenses that correct for defective distant vision as examined and approved by the AeMC, AME or GMP. Contact lenses may not be worn until cleared to do so by the AeMC, AME or GMP. A spare set of spectacles, approved by the AeMC, AME or GMP, should be readily available.

(3) VML Wear multifocal spectacles and carry a spare set of spectacles Correction for defective distant, intermediate and near vision: whilst exercising the privileges of the licence, the holder of the medical certificate should wear spectacles that correct for defective distant, intermediate and near vision as examined and approved by the AeMC, AME or GMP. Contact lenses or full frame spectacles, when either correct for near vision only, may not be worn. A spare set of spectacles, approved by the AeMC, AME or GMP, should be readily available.

(4) VNL Have available corrective spectacles and carry a spare set of spectacles Correction for defective near vision: whilst exercising the privileges of the licence, the holder of the medical certificate should have readily available spectacles that correct for defective near vision as examined and approved by the AeMC, AME or GMP. Contact lenses or full frame spectacles, when either correct for near vision only, may not be worn. A spare set of spectacles, approved by the AeMC, AME or GMP, should be readily available.

(5) CCL Wear contact lenses that correct for defective distant vision Correction for defective distant vision: whilst exercising the privileges of the licence, the holder of a medical certificate should wear contact lenses that correct for defective distant vision, as examined and approved by the AeMC, AME or GMP. A spare set of similarly correcting spectacles, approved by the AeMC, AME or GMP, should be readily available for immediate use whilst exercising the privileges of the licence.

(6) VCL Valid by day only

This limitation allows holders of a class 2 or LAPL medical certificate with varying degrees of colour deficiency, to exercise the privileges of their licence by daytime only.

(7) RXO Specialist ophthalmological examination(s)

Specialist ophthalmological examination(s), other than the examinations stipulated in Part-MED, are required for a significant reason.

(8) SIC Specific regular medical examination(s) contact the medical assessor of the licensing authority

This limitation requires the AeMC, or AME to contact the medical assessor of the licensing authority before embarking upon a revalidation or renewal aero-medical assessment. The limitation is likely to concern a medical history or additional examination(s) which the AeMC or AME should be aware of prior to undertaking the assessment.

(9) HAL Wear hearing aid(s)

Whilst exercising the privileges of the licence, the holder of the medical certificate should use hearing aid(s) that compensate for defective hearing as examined and approved by the AeMC or AME. A spare set of batteries should be readily available.

(10) APL Valid only with approved prosthesis

This limitation applies to the holder of a medical certificate with a musculoskeletalcondition when a medical flight test or a flight simulator test has shown that the use of a prosthesis is required to safely exercise the privileges of the licence. The prosthesis to be used should be approved.

(11) AHL Valid only with approved hand controls

This limitation applies to the holder of a medical certificate who has a limb deficiency or other anatomical problem which had been shown by a medical flight test or flight simulator testing to be acceptable but to require the aircraft to be equipped with suitable, approved hand controls

(12) OML Valid only as or with a qualified co-pilot

This limitation applies to holders of a class 1 medical certificate who do not fully meet the aero-medical requirements for single-pilot operations, but are fit for multi-pilot operations. Refer to MED.B.001(d)(1).

(13) OCL Valid only as a qualified co-pilot

This limitation is an extension of the OML and are restricted to the role of co-pilot.

 (14) OSL Valid only with a safety pilot and in aircraft with dual controls

This limitation applies to holders of a class 2 or a LAPL medical certificate only. The safety pilot should be made aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and should be prepared to take over the aircraft controls during flight. Refer to MED.B.001(d)(2).

(15) OPL Valid only without passengers

This limitation applies to holders of a class 2 or LAPL medical certificate with a medical condition that may lead to an increased level of risk to flight safety when exercising the privileges of the licence. This limitation is to be applied when this risk is not acceptable for the carriage of passengers. Refer to MED.B.001(d)(3).

(16) ORL Valid only with a safety pilot if passengers are carried and in aircraft with dual controls

This limitation applies to holders of a class 2 or LAPL medical certificate with a medical condition that may lead to an increased level of risk to flight safety when exercising the privileges of the licence. The safety pilot, if carried, should be made aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and should be prepared to take over the aircraft controls during flight. Refer to MED.B.001(d)(4).

(17) OAL Restricted to demonstrated aircraft type

This limitation applies to a the holder of a medical certificate who has a limb deficiency or other medical problem which had been shown by a medical flight test or flight simulator testing to be acceptable but to require a restriction to a specific class and type of aircraft.

(18) SSL Special restriction(s) as specified

This limitation may be considered when an individually specified limitation, not defined in this AMC, is appropriate to mitigate an increased level of risk to flight safety. The description of the SSL should be entered on the medical certificate or in a separate document to be carried with the medical certificate.

**SECTION 2 – MEDICAL REQUIREMENTS FOR CLASS 1 AND CLASS 2 MEDICAL**

**CERTIFICATES**

**AMC1 MED.B.010 Cardiovascular system**

ED Decision 2019/002/R

(a) Examination Exercise electrocardiography An exercise ECG when required as part of a cardiovascular assessment should be symptom limited and completed to a minimum of Bruce Stage IV or equivalent.

(b) General

 (1) Cardiovascular risk factor assessment

 (i) Serum lipid estimation is case finding and significant abnormalities should be reviewed, investigated and supervised by the AeMC or AME in consultation with the medical assessor of the licensing authority.

(ii) Applicants with an accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) should undergo a cardiovascular evaluation by the AeMC or AME, if necessary in consultation with the medical assessor of the licensing authority.

(2) Cardiovascular assessment

(i) Reporting of resting and exercise electrocardiograms should be by the AME or an accredited specialist.

(ii) The extended cardiovascular assessment should be undertaken at an AeMC or may be delegated to a cardiologist.

(c) Peripheral arterial disease

If there is no significant functional impairment, a fit assessment may be considered provided:

1. applicants without symptoms of coronary artery disease have reduced any vascular risk factors to an appropriate level;
2. (2) applicants should be on appropriate secondary prevention treatment; (3) exercise electrocardiography is satisfactory. Further tests may be required which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(d) Aortic aneurysm

(1) Applicants with an aneurysm of the infra-renal abdominal aorta of less than 5 cm in diameter may be assessed as fit before surgery, with an OML subject to satisfactory evaluation by a cardiologist. Follow-up by ultra-sound scans or other imaging techniques, as necessary, should be determined by the medical assessor of the licensing authority.

(2) Applicants may be assessed as fit with an OML after surgery for an aneurysm of the thoracic or abdominal aorta if the blood pressure and cardiovascular evaluation issatisfactory. Regular evaluations by a cardiologist should be carried out.

(e) Cardiac valvular abnormalities

(1) Applicants with previously unrecognised cardiac murmurs should undergo evaluation by a cardiologist and assessment by the medical assessor of the licensing authority. If considered significant, further investigation should include at least 2D Doppler echocardiography or equivalent imaging.

(2) Applicants with minor cardiac valvular abnormalities may be assessed as fit. Applicants with significant abnormality of any of the heart valves should be assessed as unfit.

(3) Aortic valve disease

(i) Applicants with a bicuspid aortic valve may be assessed as fit if no other cardiac or aortic abnormality is demonstrated. Follow-up with echocardiography, as necessary, should be determined by the medical assessor of the licensing authority.

(ii) with aortic stenosis may be assessed as fit provided the left ventricular function is intact and the mean pressure gradient is less than 20 mmHg. Applicants with an aortic valve orifice with indexation on the body surface of more than 0.6 cm2/m2and a mean pressure gradient above 20 mmHg, but not greater than 50 mmHg, may be assessed as fit with an OML. Follow-up with 2D Doppler echocardiography, as necessary, should be determined by the medical assessor of the licensing authority in all cases. Alternative measurement techniques with equivalent ranges may be used. Regular evaluation by a cardiologist should be considered. Applicants with a history of systemic embolism or significant dilatation of the thoracic aorta should be assessed as unfit.

(iii) Applicants with trivial aortic regurgitation may be assessed as fit. A greater degree of aortic regurgitation should require an OML. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Follow-up, as necessary, should be determined by the medical assessor of the licensing authority.

(4) Mitral valve disease

(i) Asymptomatic applicants with an isolated mid-systolic click due to mitral leaflet prolapse may be assessed as fit.

(ii) Applicants with rheumatic mitral stenosis should normally be assessed as unfit.

(iii) Applicants with minor regurgitation may be assessed as fit. Periodic cardiological review should be determined by the medical assessor of the licensing authority.

(iv) Applicants with moderate mitral regurgitation may be considered as fit with an OML if the 2D Doppler echocardiogram demonstrates satisfactory left ventricular dimensions and satisfactory myocardial function is confirmed by exerciseelectrocardiography. Periodic cardiological review should be required, as determined by the medical assessor of the licensing authority.

 (v) Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter or evidence of systolic impairment should be assessed as unfit.

(f) Valvular surgery

Applicants who have undergone cardiac valve replacement orrepair should be assessed as unfit. A fit assessment may be considered in the following cases:

(1) Mitral leaflet repair for prolapse is compatible with a fit assessment, provided postoperative investigations reveal satisfactory left ventricular function without systolic or diastolic dilation and no more than minor mitral regurgitation.

(2) Asymptomatic applicants with a tissue valve or with a mechanical valve who, at least 6 months following surgery, are taking no cardioactive medication may be considered for a fit assessment with an OML. Investigations which demonstrate normal valvular and ventricular configuration and function should have been completed as demonstrated by:

(i) a satisfactory symptom limited exercise ECG. Myocardial perfusion imaging/stress echocardiography should be required if the exercise ECG is abnormal or any coronary artery disease is suspected;

(ii) a 2D Doppler echocardiogram showing no significant selective chamber enlargement, a tissue valve with minimal structural alteration and a normal Doppler blood flow, and no structural or functional abnormality of the other heart valves. Left ventricular fractional shortening should be normal. Follow-up with exercise ECG and 2D echocardiography, as necessary, should be determined by the medical assessor of the licensing authority.

(3) Where anticoagulation is needed after valvular surgery, a fit assessment with an OML may be considered if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 international normalised ratio (INR) values are documented, of which at least 4 are within the INR target range. The INR target range should be determined by the type of surgery performed. (g) Thromboembolic disorders Applicants with arterial or venous thrombosis or pulmonary embolism should be assessed as unfit. A fit assessment with an OML may be considered after a period of stable anticoagulation as prophylaxis, after review by the medical assessor of the licensing authority. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range and the haemorrhagic risk is acceptable. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an OML may be considered after review by the medical assessor of the licensing authority after a stabilisation period of 3 months. Applicants with pulmonary embolism should also be evaluated by a cardiologist. Following cessation of anticoagulant therapy, for any indication, applicants should undergo a re-assessment by the medical assessor of the licensing authority