Inspectie Leefomgeving en Transport
Ministerie van Infrastructuur en Waterstaat

MENTAL HEALTH ASSESSMENT

Name of applicant						
Date of birth						
Date of examination						
Class	1	2	3	LAPL	Initial	Revalidation/Renewal

TO BE COMPLETED BY APPLICANT

Do you have, or did you ever have, any of the following? (Please tick). If yes, give details in remarks section

	YES	NO	Not sure
Mental health problems of any sort Including: Depression, Anxiety, Burn out, Stress-related disorder, Panic attack, Manic episode, Depressive episode, Bipolar disorder, Personality disorder (incl. borderline), Self- harm, Suicide attempt / thoughts, Alcohol/ drugs/ medication related disorder, ADHD, Autism			
Treatment or assessment by a psychologist or psychiatrist			
Work and/or life stressors that could affect flight safety			
Difficulties with employer /colleagues/ Operational Crew Resource Management			
Interpersonal or relationship issues			
Childhood behavioural problems			
Remarks			

Declaration:

I hereby declare that I have carefully considered the statements made above and to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statements. I understand that, if I have made any false or misleading statements in connection with this application, or fail to release the supporting medical information, the licensing authority may refuse to grant me a medical certificate or may withdraw any medical certificate granted, without prejudice to any other action applicable under national law.
CONSENT TO RELEASE OF MEDICAL INFORMATION: I hereby authorise the release of all information contained in this report and any or all attachments to the AME and, where necessary, to the medical assessor of the my licensing authority , to the medical assessor of the competent authority of my AME and to relevant medical professionals for the purpose of completion of an aero-medical assessment or a secondary review, recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. Medical confidentiality will be respected at all times.

……	……	……
Date	Signature of applicant	Signature of AME

MENTAL HEALTH ASSESSMENT

Name of applicant	
Date of birth	
Date of examination	

TO BE COMPLETED BY AME

Checklist Symptoms:

	YES	NO
Loss of interest/energy		
Eating and weight changes		
Sleeping problems		
Low mood, and, if present, any suicidal thoughts		
Anger, agitation or high mood		
Depersonalisation or loss of control		
Remarks		

Checklist Assessment / Examination:

	Normal	Abnormal
Appearance		
Attitude		
Behaviour		
Mood		
Speech		
Thoughts process and content		
Cognition		
Insight		
Judgement		
Coping strategies under periods of psychological stress or pressure in the past		
General attitudes to mental health, including seeking help of others		
Remarks		

Examiner declaration:

I hereby certify that I have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

…….	…….	…….
Name of AME	Date	Signature