BOARD OF COMMISSIONERS OF PILOTS
OF THE STATE OF NEW YORK
17 BATTERY PLACE
NEW YORK, NY 10004

TEL: 212 - 425-5027
FAX: 212 - 344-3144

HEALTH CERTIFICATION AND CONSENT

NAME OF PILOT:

AFFILIATION:

HAVE YOU IN THE PAST TWELVE MONTHS:			**INITIALS**
1. Had to utilize the services of a hospital, emergency room or urgent care facility - If yes, please describe the circumstances:	YES	NO	_____
2. Undergone any surgery - If yes, please describe:	YES	NO	_____
3. Added, deleted or changed prescriptions - If yes, please explain which one(s):	YES	NO	_____
4. Changed Primary Care physician - If yes, name and address of new physician: Reason for change:	YES	NO	_____
5. Seen other physicians or specialists - If yes, please provide name(s), address(s) and specialty:	YES	NO	_____

I consent to allow the Board of Commissioners of Pilots to provide my Physical Examination Reports, Medical Records, and Duties and Responsibilities Form to the Board appointed Medical Review Physician.

Upon written request, I may see or copy any information provided pursuant to this form.

This consent remains in force until my next renewal.

I acknowledge that a false statement may result in sanctions.

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Signature Date