CANDIDATE'S STATEMENT
AVIATION MEDICAL EXAMINATION

PLEASE FILL IN THE FOR USING CAPITAL LETTERS AND MARK X IN SUITABLE SQUARES

....

First and last name *PESEL / Passport number*

Today, before my aviation and/or occupational medicine examinations, I declare that:

1. I am rested, I feel healthy and ready to undergo examinations, and for the last 24 hours I have not consumed alcohol and cared for rational nutrition. I put myself on an empty stomach for tests. I am not on sick leave.
2. I have read carefully the statements regarding my state of health and medical history included in the Application Form for the Medical Certificate, and the data I complete are, to the best of my knowledge, true and complete. I did not conceal any relevant information and did not put any misleading statements. I understand that providing incomplete or false data in the Form may result in a negative medical certificate issued by a certifying physician or an authority entitled to licensing may refuse to issue a decision or withdraw all issued decisions aviation medical notifications in addition to all other operations applicable under national law.
3. I have been informed that pursuant to art. 106 section 3 of the Act of 3 July 2002 - Aviation Law (Journal of Laws of 2019, Pos. 1580 and 1495) I have the right to appeal against a medical certificate issued by a doctor aero-medical certificate to the Chief Civil Aviation Doctor within 14 days of receipt judgment. Appeals against medical certificates are submitted to the Chief Civil Aviation Doctor through the certifying doctor by whom it was issued.
4. I am aware that a visit at this facility in an epidemiological situation is associated with an increased risk of infection with SARS CoV-2 coronavirus.

5. ADDITIONAL QUESTIONNAIRE RELATED TO EPIDEMIOLOGICAL SITUATION

Are you currently quarantined?	☐ YES	☐ NO
Have you been outside Poland in the coronavirus transmission areas during the last 14 days? (list of countries published daily at www.gis.gov.pl)	☐ YES	☐ NO
During the last 14 days, have you had contact with the person with a confirmed SARS CoV-2 coronavirus infection?	☐ YES	☐ NO
Have you had a contact with a person, who is currently quarantined?	☐ YES	☐ NO
Do you have any symptoms:		
– A fever above 38 degrees C	☐ YES	☐ NO
– Muscle aches	☐ YES	☐ NO
– Cough	☐ YES	☐ NO
– Feeling short of breath - difficulty in taking a breath	☐ YES	☐ NO
– Smell and / or taste disturbances which have occurred in the last 14 days	☐ YES	☐ NO
– Diarrhea	☐ YES	☐ NO

I acknowledge that Romana Borkowska, operating under the name ALERGO-MED Poradnia Specjalistyczna, is the administrator of personal data regarding my person for the purposes of providing medical services. I have been informed about the right to access the content of the above data and the right to amend, update, supplement and delete them. I have read the information obligation arising from art. 13 GDPR (available at alergo-med.com and badanialotniczolekarskie.pl and on ALERGO-MED clinic information boards).

PART FILLED IN BY A MEDICAL EMPLOYEE

Temperature .....°C

..... *Medical employees signature*

..... *Date and Patient's / legal guardian's signature*

Legal basis: art. 9 item 2 letter i) GDPR and art. 17 of the Act of March 2, 2020 on special solutions related to the prevention, prevention and eradication of COVID-19, other infectious diseases and crisis situations caused by them.