



Personnel Licensing

FSS PEL 67-05

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APPLICATION FOR DESIGNATION AS AVIATION MEDICAL SPECIALIST CONSULTANT

NOTE:

1. After completion this form must be submitted to the NCAA Medical Assessor together with the following:
 - a. Certified Copy of ID Document or Passport;
 - b. Certified Copy of Proof of Medical Degree
 - c. Certified copies of Certificate, diploma or degrees of any postgraduate professional training;
 - d. Certified Copy of Namibian Medical and Dental Council registration certificate as Specialist;
 - e. Certified Copy of Namibian Medical and Dental Council certificate of good standing;
 - f. References from three physicians in applicant's geographical location regarding professional standing, OR a statement from the office of the medical society in the locality of practice, that the applicant is a medical doctor in good standing;
 - g. Certified Copy of Certificate of aviation medicine training;
 - h. Proof of practical knowledge and experience of the conditions in which the holders of licences and ratings carry out their duties;
 - i. A statement affirming that –
 - i. there are no current restrictions of medical practice, and there are no adverse actions proposed or pending by the Namibian Medical and Dental Council that would limit medical practice; and
 - ii. there are no known investigations, charged indictments, or pending actions in any court of law.
 - i. Proof of the ability to read, write, speak, and understand the English language.

PART 1: PERSONAL DETAILS (TO BE COMPLETED BY APPLICANT)

Surname <i>(Block letters)</i>							
First names							
Gender <i>(check box)</i>	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Nationality		
Identity/Passport Number					Date of birth		
Practice address					Postal address		
Telephone Number					Mobile phone Number		
Fax Number					Email address		
Citizen	<input type="checkbox"/>	Work Permit	<input type="checkbox"/>	Permanent resident	<input type="checkbox"/>	Practice number:	
Discipline:	<input type="checkbox"/> GP	<input type="checkbox"/> Specialist	Specialty Area:			HPCNA number:	
Foreign registration:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Country:			Special interest?	

PART 2: EQUIPMENT DETAILS (TO BE COMPLETED BY THE APPLICANT)

Please indicate which of the following equipment are to your disposal at your rooms.

Access to computer equipment	Yes	No	Will acquire	Will not acquire
Computer with high-speed internet access				
Scanner				
Printer				

Comments:

PART 3: DECLARATION

- I, the undersigned declare and certify that:
- a. The information submitted to NCAA is correct;
 - b. I have not been denied an Aviation Medical Specialist Designation before;
 - c. I am aware that designation is at the sole discretion of the Director, is a privilege and not a right, and may be withdrawn at any stage;
 - d. I am familiar with the contents of all regulations that applies to my designation, including Part 185 (Offences); and
 - e. I am aware that honesty and integrity are essential prerequisites for designation and the maintenance thereof.

I undertake to at all times:

- a. Provide correct information to the NCAA,
- b. Comply with the applicable regulations as contained in NAMCAR and NAMCATS 67 as pertaining to my designation,
- c. Uphold and maintain the medical examination standards,,
- d. Exercise my duties as a consultant without bias and prejudice,
- e. Be honest and fair in all assessments,
- f. Act professionally and with integrity, and
- g. Ensure that any potential conflict of interest with any candidate are declared to the Medical Assessor in advance of any assessment being conducted.

Date:		Signature of examiner	
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OFFICIAL USE ONLY

Date: Application reviewed		Application	Approved		Date:		Rejected		Date:
NCAA employee Name:		NCAA Supervisor Name:		Reason:					
Signature:		Signature:							