Telephone number:	+264 83 235 2485	*Fax Number:*	+264 TBA
Physical address:	No.4 Rudolph Hertzog Street, Windhoek, NAMIBIA		
Postal address:	Private Bag X12003, Ausspannplatz, Windhoek, NAMIBIA	*E-mail*	licensing@ncaa.na

APPLICATION FOR DESIGNATION AS AVIATION MEDICAL EXAMINER

NOTE:

1. After completion this form must be submitted to the NCAA Medical Assessor together with the following:
   a. Certified Copy of Proof of medical degree;
   b. Certified copies of Certificate, diploma or degrees of any postgraduate professional training;
   c. Certified Copy of Namibian Medical and Dental Council registration certificate;
   d. Certified Copy of Namibian Medical and Dental Council certificate of good standing;
   e. 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;
   f. Certified Copy of Certificate of aviation medicine training;
   g. Proof of practical knowledge and experience of the conditions in which the holders of licences and ratings carry out their duties;
   h. 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 *(Block letters)*							
First names							
Gender *(check box)*	Male		Female		Nationality		
Identity/Passport Number					Date of birth		
Practice address					Postal address		
Telephone Number					Mobile phone Number		
Fax Number					Email address		
Citizen ☐	Work Permit ☐		Permanent resident ☐		Practice number:		
Discipline:	☐ GP ☐ Specialist		Specialty Area:		HPC number:		
Foreign registration:	☐ No ☐ 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. If you do not have the equipment, please indicate who you refer to, as well as the approximate distance to be travelled by the applicant, from your facility to the referred facility.

Item	Yes, have available	No, refer to:	Distance
Multi-channel ECG			
Flow-volume loop lung function machine			
Orthorator/OPTEC 2000			
Ishihara charts			
Equipment to determine phorias, specify: _____			
Audiometer			

Access to computer equipment	Yes	No	Will acquire	Will not acquire
Computer with modem and 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 Examiner 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 aware that I will be subjected to annual oversight by the NCAA Medical Assessor for the purpose of maintenance of standards and re-designation;
e .I am familiar with the contents of all regulations that applies to my designation, including Part 185 (Offences); and
f .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. Conform to all procedures of the Designated Aviation Medical Examiner Manual,
e. Exercise my duties as an examiner without bias and prejudice,
f. Be honest and fair in all assessments,
g. Act professionally and with integrity, and
h. 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	

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