

AME EQUIPMENT AND MEDICAL CONFIDENTIALITY (Updated 12/11/2024)

AMEs must have adequate facilities and equipment for performing the required physical examinations. AMEs shall certify, at the time of designation, prior to conducting any FAA examinations, re-designation, or upon request, that they possess and maintain as necessary the equipment specified below.

Please indicate the items available in your office with a checkmark.

ITEM	SPECIFICATIONS
<p>VISION TESTING 1. VISUAL ACUITY</p> <p>PHORIA TESTING</p> <p><input type="checkbox"/> 1. A. TESTING EXCEPTION</p>	<p>VISUAL ACUITY TESTING: Must have all the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Standard Snellen test for distance visual acuity, with appropriate eye lane and lighting. <input type="checkbox"/> FAA Form 8500-1, Near Vision Acuity Card for near and intermediate vision testing <input type="checkbox"/> Opaque eye occluder <p>PHORIA TESTING: Must have at least one option from EACH category: Prisms, Red Maddox Rod, and Eye Muscle Test Light:</p> <p>Prisms - Must have at least one of the following: To measure heterophoria, must begin with 1 prism diopter and increase to at least 8 prism diopters for BOTH horizontal and vertical.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Risley rotary prism device <input type="checkbox"/> Prism bars: BOTH horizontal and vertical <input type="checkbox"/> Individual hand prisms <p>Red Maddox Rod - Must have at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maddox Rod included in Risley rotary prism device <input type="checkbox"/> Maddox Rod handheld <p>Eye Muscle Test Light - Must have at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscle light <input type="checkbox"/> Ophthalmoscope light <input type="checkbox"/> Penlight 0.5cm in diameter
<p><input type="checkbox"/> 1. B. MANUAL TESTING</p>	<p>Optional substitute: Any commercially available visual acuity and heterophoria- testing device that gives distance and near acuity in Snellen equivalents is acceptable for the equipment listed in 1.A. It is strongly recommended that if using a commercial device, that both a Snellen wall chart and near vision acuity card are available to recheck testing, if needed.</p> <p>If applicable, check the box below and write the name of the device.</p> <p><input type="checkbox"/> I use the following commercially available visual acuity and heterophoria testing device(s) in my office:</p> <p>Device name: _____</p>

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<p>2. COLOR VISION TESTING</p> <p>Must have in office:</p> <p>OR</p> <p>Access to:</p> <p>OR</p> <p>Ability to give the applicant a referral for testing with one of the approved color vision tests:</p>	<ul style="list-style-type: none"> o City Occupational Colour Assessment & Diagnosis (CAD; AVOT-PRO-US) o Rabin Cone Test (RCCT) Air Force/Army/Navy/Coast Guard Version o Waggoner Computerized Color Vision Test
<p>3. FIELD OF VISION TESTING – must have at least ONE of the following:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Direct confrontation field-testing (must test all 4 quadrants). No equipment required <input type="checkbox"/> Wall Target (50-inch square surface made of black felt or dull/matte finish paper; and a 2-mm white test object, which may be a pin with a handle the same color as the wall target. <input type="checkbox"/> Visual Field Perimeter (must test all 4 quadrants).
<p>4. OTHER OFFICE EQUIPMENT – must have ALL of the following:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Computer with internet access and printer <input type="checkbox"/> Diagnostic instruments necessary to complete FAA exam <input type="checkbox"/> Equipment to measure height and weight <input type="checkbox"/> Urinalysis Test Strips to test for albumin and sugar <p>Urine dipstick expiration date on package: _____</p>
<p>5. SENIOR AME - SPECIAL EQUIPMENT REQUIRED – must have the following:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Access to electrocardiograph (EKG/ECG) equipment (preferably at your office location) <p>Brand of ECG equipment _____</p>
<p>6. EMPLOYEE AME - SPECIAL EQUIPMENT REQUIRED - must have the following</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Audiometric Equipment. Brand: _____ <input type="checkbox"/> Calibration date: _____

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I hereby certify that I possess and maintain as necessary the equipment specified above in my office or available at the designated location below:

Address: _____

City: _____ State: _____ Zip code: _____

Country (if outside the US) _____

Telephone Number (Include Area Code): _____

Signature: _____ Date: _____

AND

I hereby certify that I maintain confidentiality of medical records at all times.

Signature: _____ Date: _____

Printed Name: _____ AME number: _____