Anxiety, Depression, and Related Conditions (OFF Treatment)

FAST TRACK PATHWAY for the AME

All Classes
(Updated 11/18/2026)

APPLICANT NAME: _____ **DATE OF BIRTH:** _____

APPLICANT ID#: _____ **PI#:** _____

Step 1: Determine Who Completes the Mental Health History Checklist (MMH Checklist).

** Note: The Mental Health History Checklist is a separate required document that must be downloaded and filled out prior to completing this OFF Treatment Fast Track Pathway.*

Evaluate the time elapsed since the applicant's **last treatment OR last active symptoms** (whichever is more recent): Date of last treatment or symptoms: ____ / ____ / _____

- **Less than 2 years:** STOP. Not applicable for FAST TRACK. Defer exam.
- **2 to 5 years ago: MHH Checklist** MUST be completed by an FAAR Psychiatrist, Board Certified Psychiatrist, or PCP (including mid-levels).
- **More than 5 years ago:** The AME can complete the Mental Health History Checklist.

Step 2: AME FAST TRACK Screening

Review the completed Mental Health History Checklist & clinical records to answer the following:

1. Has the individual been prescribed or taken any mental health medication within the past two (2) years?	No	Yes
2. Are any items checked "Yes" on the completed Mental Health History Checklist?	No	Yes
3. Are any required clinical records, notes, or checklist items missing or unavailable for review?	No	Yes
4. Do you have any aeromedical concerns regarding this individual's ability to safely operate in the National Airspace System (NAS)?	No	Yes

Step 3: AME Disposition

If ALL 4 are "No" → ISSUE CERTIFICATE (if otherwise qualified).
Counsel the airman to self-ground under 14 CFR § 61.53 if their condition changes or treatment resumes.

If ANY "Yes" → STOP (DO NOT ISSUE). Defer application to the FAA.
Upload this worksheet (as *Beh Hlth – Anxiety, Depression, Fast Track – OFF Treatment*), the Mental Health History Checklist, and all clinical records to the FAA.

I have reviewed all required documentation and will notify the FAA of any adverse change in clinical status or symptom recurrence.

AME Name: _____ **AME Number:** _____

Signature: _____ **Date of Exam:** _____