

**SEIZURE**  
All Classes  
(Updated 01/25/2023)

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
<p><b>A. Simple Febrile Seizure</b> occurring at</p> <p><b>Age 5 or younger</b></p> <p>(fever seizure/febrile seizure)</p>	<p>If the AME can determine all of the following apply:</p> <ul style="list-style-type: none"> <li>• <b>A single seizure only;</b></li> <li>• Condition fully resolved age 5 or younger;</li> <li>• NO recurrence;</li> <li>• NO anticonvulsant medication given; AND</li> <li>• Condition has resolved without sequelae with NO symptoms or current problems that would interfere with flight duties:</li> </ul> <p>If the AME is unable to determine all of the above information, a <b>detailed neurological evaluation</b> that meets <a href="#">FAA Specifications for Neurologic Evaluation</a> generated from a clinic visit with the treating neurologist will be required.</p> <p>If the neurology evaluation verifies the condition was a simple febrile seizure:</p>	<p style="background-color: #008000; color: white; text-align: center;"><b>ISSUE</b></p> <p>Annotate this information in Block 60.</p> <p>All others, go to Row C</p>
<p><b>B. Single seizure</b> even <b>provoked</b> by a known cause which has been corrected</p> <p>May be due to:</p> <p>Electrolyte or severe metabolic imbalance;</p> <p>Medication use;</p> <p>or</p> <p>Convulsive syncope;</p> <p>If due to TBI or post concussive seizure - see that section</p> <p>If due to drug or alcohol withdrawal - see D&amp;A section</p>	<p>After a <b>One (1)-year recovery</b> period, submit the following for FAA review:</p> <ol style="list-style-type: none"> <li>1. A <b>current, detailed neurological evaluation</b> that meets <a href="#">FAA Specifications for Neurologic Evaluation</a> generated from a clinic visit with the <b>treating neurologist no more than 90 days</b> before the AME exam.</li> <li>2. It <b>must specifically include</b> the date of last seizure activity and dates medication discontinued.</li> <li>3. <b>*MRI brain</b> performed at any time after the seizure activity started. <ul style="list-style-type: none"> <li>• If not already performed, a current brain MRI is required.</li> <li>• Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICODEDIR' in the root directory of the CD-ROM). Please verify</li> </ul> </li> </ol>	<p style="background-color: #800000; color: white; text-align: center;"><b>DEFER</b></p> <p>Submit the information to the FAA for a possible Special Issuance</p>

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
	<p>the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail.</p> <p>4. <b>Electroencephalogram (EEG)</b> performed <b>no more than 12 months before the AME exam</b>. It must be sleep-deprived EEG: Awake, asleep, and with provocation (hyperventilation, photic/strobe light).</p> <ul style="list-style-type: none"> <li>• If not already performed, a current EEG is required.</li> <li>• Submit any previous EEG(s) available for comparison.</li> <li>• Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail.</li> </ul> <p>5. <a href="#">FAA Airman Seizure Questionnaire</a> completed by the applicant.</p> <p><b>Note:</b> In some cases, a longer recovery period will be required based on the underlying cause.</p>	
<p><b>C. Single seizure event UNPROVOKED</b> (No known cause) OR <b>Complex febrile seizure;</b> Atypical/complex febrile seizures; or febrile seizures treated with medication as a child (usually age 5 or younger).  <b>Note: If 2 or more seizures in a lifetime</b>, from any cause, go to the <b>Epilepsy section</b>.</p>	<p>After a <b>four (4)-year recovery period and the last two (2) years must be without anticonvulsant medication</b>, submit the following for FAA review:</p> <ul style="list-style-type: none"> <li>• All information in Row B.</li> </ul> <p>Upon review, additional information may be required.</p>	<p><b>DEFER</b></p> <p>Submit the information to the FAA for a possible Special Issuance</p>

**EPILEPSY**  
**(Seizure Disorder)**

All Classes  
(Updated 05/31/2023)

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
<p><b>A. Epilepsy by history</b></p> <p><b>Seizure-free for ten (10) years</b></p> <p><b>AND</b></p> <p><b>Off medication for the last 3 years</b></p>	<p>After a <b>ten (10)-year seizure-free recovery</b> period, obtain the following and submit for FAA review:</p> <ol style="list-style-type: none"> <li>1. A <b>current, detailed neurological evaluation</b> that meets <a href="#">FAA Specifications for Neurologic Evaluation</a> generated from a clinic visit with the treating neurologist (<b>epileptologist preferred</b>), <b>no more than 90 days before</b> the AME exam.</li> <li>2. It <b>must specifically include</b> the date of last seizure activity and dates medication(s) discontinued.</li> <li>3. <b>MRI brain</b> performed at any time after the seizure activity started. <ul style="list-style-type: none"> <li>• If not already performed, a current brain MRI is required. Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail.</li> </ul> </li> <li>3. <b>Electroencephalogram (EEG)</b> performed no more than <b>12 months before</b> the AME exam. It must be sleep-deprived EEG: awake, asleep, and with provocation (hyperventilation, photic/strobe light). A 24-hour EEG study is preferred. <ul style="list-style-type: none"> <li>• If not already performed, a current EEG is required.</li> <li>• Submit any previous EEG(s) available for comparison.</li> <li>• Submit BOTH the interpretive report(s) on paper and a copy of</li> </ul> </li> </ol>	<div style="background-color: red; height: 20px; width: 100%;"></div> <p style="text-align: center;"><b>DEFER</b></p> <p>Submit the information to the FAA for a possible Special Issuance.</p>

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
	<p>the EEG recording(s) on CD with proprietary opening software that is compatible with Windows 10. You may wish to retain a copy of all films as a safeguard if lost in the mail.</p> <p>4. <a href="#">FAA Airman Seizure Questionnaire</a> completed by the applicant.</p>	
<p><b>B. SeLECTS</b> (Self-limited Epilepsy with Centrotemporal Spikes).</p> <p><b>Seizure-free for four (4) years</b></p> <p>AND</p> <p><b>Off medication for the last two (2) years</b></p> <p>This condition may also be called:</p> <ul style="list-style-type: none"> <li>• Rolandic Epilepsy,</li> <li>• Benign Rolandic Epilepsy (BRE),</li> <li>• BECTS (Benign Epilepsy with Central Temporal Spikes), or</li> <li>• CECTS (Childhood Epilepsy with Central Temporal Spikes)</li> </ul>	<p>After a <b>four (4)-year seizure-free recovery</b> period, obtain and submit for FAA review:</p> <ul style="list-style-type: none"> <li>• Evaluation Data Row A</li> </ul>	<div data-bbox="1230 611 1458 642" style="background-color: red; height: 15px; width: 100%;"></div> <p><b>DEFER</b></p> <p>Submit the information to the FAA for a possible Special Issuance.</p>

## FAA Pilot/ATCS Seizure Questionnaire (Updated 09/28/2022)

The following questions should be answered by the AIRMAN who should read through the entire questionnaire and complete all sections as appropriate. If the seizures occurred when the airman was a child, a parent or guardian familiar with the episodes should complete this questionnaire.

**Circle, check, or fill in answers, as appropriate:**

SECTION 1 - BIG SEIZURES			
Have you ever had a grand mal seizure or a big seizure where you lost consciousness or your whole body shook and stiffened?	Yes  <b>Go to A</b>	No  <b>Go to Section 2</b>	
<b>A.</b> How many have you had? Enter a number:			
<b>B.</b> When was the first one? <i>Enter approximate date, how long ago, or your age at the time:</i>	Date:	Or Months ago:	Or age:
<b>C.</b> When was the last one/most recent <i>Enter the approximate date:</i>	Date:		
<b>D.</b> Do you ever have a warning before your big seizure(s)?	Yes	No  <b>Go to E</b>	Don't Know
<b>D1.</b> Did you ever have this warning and not have a seizure?	Yes	No	Don't know
<b>D2.</b> When was the last warning? <i>Enter actual date OR how long ago (in months)</i>	Date:	Or Months ago:	
<b>D3.</b> Did this warning consist of any of the following?			
a. Unusual feeling in stomach or chest	Yes	No	Don't know
b. Unusual smells or tastes?	Yes	No	Don't know
c. Hearing unusual sounds or hearing difficulty?	Yes	No	Don't know
d. See anything unusual, or have any change in your vision?	Yes	No	Don't know
e. Behave in unusual ways such as smacking your lips, touching your clothes, or doing any other unusual things without intending to?	Yes	No	Don't know
f. Have difficulty speaking or understand speech?	Yes	No	Don't know
<b>E.</b> Of the grand mal or big seizures that you had while awake, did they usually occur shortly after waking up? (Either in the morning or after a nap.)	Yes	No  <b>Go to F</b>	Don't know
<b>E1.</b> How many minutes after waking up would you say the grand mal or big seizure(s) usually occurred? <i>Check one</i>	<input type="checkbox"/> 15 min or less <input type="checkbox"/> 16-30 min <input type="checkbox"/> 31-45 min <input type="checkbox"/> 46-60 min <input type="checkbox"/> More than 60 min		
<b>F.</b> Before the seizure started, did you have jerking, shaking, or uncontrolled body movements or did your whole body jump suddenly, as if someone had startled you from behind?	Yes	No  <b>Go to Section 2</b>	Don't know
<b>F1.</b> Which side was affected? <i>Check one</i>	<input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> Both sides <input type="checkbox"/> One side; unsure of which <input type="checkbox"/> Don't know		

**Airman Name** (printed) \_\_\_\_\_ **MID#, PI#, or App D#** \_\_\_\_\_

SECTION 2 - SMALL SEIZURES			
Have you ever had any small spells (other than grand mal or big seizures)?	Yes  <b>Go to A</b>	No  <b>Go to Section 3</b>	
A. When was the last time you had one of these spells? <i>Write in the approximate date OR age at which it occurred.</i>	Date:	Or age:	
B. How long would you say the spell lasted? <i>Check one</i>	<input type="checkbox"/> 15 secs or less <input type="checkbox"/> 16-30 secs <input type="checkbox"/> 31 -59 secs <input type="checkbox"/> 1-2 min <input type="checkbox"/> More than 2 min		
C. During this most recent spell, which of the following best describes your awareness of the surroundings? <i>Check one</i>	<input type="checkbox"/> Fully aware <input type="checkbox"/> Fully unaware <input type="checkbox"/> Somewhat aware, but less aware than usual		
D. During this spell, were you able to FUNCTION as you normally do?	Yes	No	Don't know
E. During this spell, were you able to COMMUNICATE as you normally do?	Yes	No	Don't know
F. After the spell was over, did you remember what happened during the spell or did you learn about it from someone else?	<input type="checkbox"/> Yes, I remembered	<input type="checkbox"/> No, someone else had to tell me	
G. During this spell, did any parts of your body move uncontrollably?	Yes	No  <b>Go to H</b>	Don't know
G1. Which parts of the body were involved?	<input type="checkbox"/> Arm <input type="checkbox"/> Face <input type="checkbox"/> Don't know <input type="checkbox"/> Leg <input type="checkbox"/> Other		
G2. Was this only on one side?	Yes	No	Don't know
H. During this spell, did any parts of your body JERK suddenly and unexpectedly?	Yes	No  <b>Go to I</b>	Don't know
H1. Which parts of the body were involved?	<input type="checkbox"/> Arm <input type="checkbox"/> Face <input type="checkbox"/> Total body <input type="checkbox"/> Leg <input type="checkbox"/> Other <input type="checkbox"/> Don't know		
H2. Was this on only ONE SIDE?	Yes	No  <b>Go to I</b>	Don't know
H3. Which side?	<input type="checkbox"/> Left only <input type="checkbox"/> Right only <input type="checkbox"/> One side but unsure which <input type="checkbox"/> Unsure		
H4. Have you ever had a similar spell with jerking on the opposite side?	Yes	No	Don't know
H5. Would you say the jerking felt like an electric shock going through your body?	Yes	No	Don't know
H6. Has this type of spell usually occurred shortly after waking up (either in the morning or after a nap)?	Yes	No	Don't know
H7. Does this type of spell occur only when you are going to sleep?	Yes	No	Don't know
H8. Did this type of spell ever occur as a result of lights shining in your eyes (for example strobe lights, video games, reflections or sun glare?)	Yes	No	Don't know
I. During this spell, did you behave in unusual ways such as smacking your lips, touching your clothes, or doing any other unusual things without intending to?	Yes	No	Don't know

SECTION 2 - SMALL SEIZURES			
J. Did your eyelids flutter during this spell?	Yes	No	Don't know
K. Do you tend to be clumsy in the morning such as dropping things or spilling coffee or other drinks?	Yes	No	Don't know
L. During your spells, did you ever have any other symptoms?	Yes (Explain in Section 5)	No	Don't know

SECTION 3 - OTHER			
Do you ever have unexplained episodes of any of the following?			
A. Unusual feelings in your stomach or chest?	Yes	No	Don't know
B. Unusual smells or tastes?	Yes	No	Don't know
C. Hearing unusual sounds or hearing difficulty?	Yes	No	Don't know
D. Seeing anything unusual or have any changes in your vision	Yes	No	Don't know
E. Behaving in unusual ways such as smacking your lips, touching your clothes, or doing any other unusual things without intending to?	Yes	No	Don't know
F. Having periods of lost time due to "spacing out" or daydreaming?	Yes	No	Don't know
G. Awakening in the morning with a bitten tongue or a bloody pillow?	Yes	No	Don't know
H. Awakening in the morning with unexplained bed-wetting?	Yes	No	Don't know
I. Other (or comments)	Yes Explain in Section 5	No	Don't know

SECTION 4 - MEDICATION HISTORY			
A. I am currently taking medication to prevent or control my seizures	Yes	No Go to B	Don't know
A1. I am currently taking medication to prevent or control my seizures	Yes	No	Don't know
A2. Current medication: <i>If you do not know the date or calendar year, enter your age when medication was started.</i>	Medication name:	Dosage	Date or age
B. I took medication in the past.	Yes	No Go to Section 5	Don't know
B1. Previous medication: <i>If you do not know the date or calendar year, enter your age when medication was stopped.</i>	Medication name:	Dosage	Date or age

**Airman Name** (printed) \_\_\_\_\_ **MID#, PI#, or App D#** \_\_\_\_\_

## SECTION 5 - COMMENTS

Please enter additional explanation or comments for ANY part of this questionnaire:

**\*\*If anyone other than the pilot/ATCS completed this questionnaire, list name and relationship to the airman\*\***

**Name:**

**Relationship:**

**Signature** \_\_\_\_\_ **Date completed** \_\_\_\_\_

**Airman Name** (printed) \_\_\_\_\_ **MID#, PI#, or App D#** \_\_\_\_\_