



U.S. Department of Transportation
Federal Aviation Administration

**U.S. DEPARTMENT OF TRANSPORTATION
Federal Aviation Administration**

REQUEST FOR AIRMAN MEDICAL RECORDS

PRIVACY ACT: This information is required under the authority of Transportation Title 49 U.S.C. Section 44703 et. seq., the Privacy Act at 5 USC § 552a(b), and the Freedom of Information Act at 5 USC § 552. The principal purpose for which the information is intended to be used is to 1) enable the agency to locate and retrieve the records that you are requesting, and 2) ensure that any applicable Privacy Act requirements for access to these records have been met. Your request cannot be processed unless the data below is complete. Submission of the data requested on this form is voluntary, and refusal to furnish the information will not result in the denial of any right, benefit, or privilege provided by law; however, failure to provide the requested information may result in the delay of a response or the processing of your inquiry, or a denial of your request for records. The information collected on this form will be included in a Privacy Act System of Records, which is covered by System of Records Notice (SORN) DOT/ALL 17 titled, "Freedom of Information Act and Privacy Act Case Files" and will be subject to the routine uses published in that SORN. These routine uses allow disclosure of the information under the following circumstances: 1) to another federal agency (a) with an interest in the record in connection with a referral of a Freedom of Information Act (FOIA) request to that agency for its views or decision on disclosure, or (b) in order to obtain advice and recommendations concerning matters on which the agency has specialized experience or particular competence that may be useful to the Department of Transportation (DOT) in making required determinations under the FOIA.; and 2) DOT Prefatory Statement of General Routine Uses, which can be found at <https://www.transportation.gov/individuals/privacy/privacy-act-system-records-notices>.

Last First Middle
Full Name (as it appears on your medical certificate)

Date of Birth (MM/DD/YYYY) FAA Medical Reference Number (App ID, MID, PI)

Current Mailing Address: Street Address, Apt./Suite No., PO Box/Rural Route No.

City State Zip Code

There may be a fee for copies. If the cost is \$25.00 or more the requester will be notified and asked for concurrence to pay in written form (fax, e-mail or postal service).

Please check the appropriate box for the records you would like to obtain.

Complete Airman Medical File Partial Airman Medical File _____

Specify the date range or specific documents needed.

I authorize the Federal Aviation Administration to release copies of my airman medical records to the person or company listed below:

Mailing Address: Street Address, Apt./Suite No., PO Box/Rural Route No.

City State Zip Code

Mail this request to: **Federal Aviation Administration
Aerospace Medical Certification Division, AAM-331
CAMI, Building 13
PO Box 25082
Oklahoma City, OK 73125-9867** Or Fax to: **(405) 954-9326**
ONE FORM PER REQUEST PLEASE.

Statement Under Perjury: I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than \$10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than \$5,000.

Airman Signature _____
(Typed or printed signature is not acceptable.) Date