STATE OF KUWAIT
Directorate General of Civil Aviation

دولة الكويت
الإدارة العامة للطيران المدني

Date : 2024/05/9 التـــاريخ :

Ref : 2024/039/SUPDT-R/41 الإشارة :

All KCASR Stakeholders and Users

Sub.: ***Regulatory Circular No. 2024-03.***
Revision Number 4 to Kuwait Civil Aviation Safety Regulations – PERSONNEL LICENSINGPART MED – ACCEPTABLE MEANS OF COMPLIANCE (AMC) & GUIDANCE MATERIALS (GM).

Dear Sir,

Please find enclosed herewith the regulatory circular No. ***2024-03*** regarding the issuance of ***PERSONNEL LICENSINGPART MED – ACCEPTABLE MEANS OF COMPLIANCE (AMC) & GUIDANCE MATERIALS (GM) Rev. 4***. This is for your information and distribution to all concerned departments.

Up to date KCASR Parts are published on the DGCA/ASD website (https://kcasr.dgca.gov.kw).

If required, the DGCA/Aviation Safety Department personnel are available to answer your questions on the interpretation and intended implementation of the proposed amendments.

PERSONNEL LICENSINGPART MED – ACCEPTABLE MEANS OF COMPLIANCE (AMC) & GUIDANCE MATERIALS (GM) Rev. 4 will be in effect from 02/Jun/2024.

Yours Sincerely,

President of Civil Aviation.

Abdullah F. Alrajhi
Acting / Deputy Director General
for Aviation Safety, Air Transport & Aviation Security

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STATE OF KUWAIT
Directorate General of Civil Aviation

دولة الكويت
الإدارة العامة للطيران المدني

Date : 2024/05/9 التـــاريخ :

Ref : 2024/040/SUPDT-R/41 الإشارة :

REGULATORY CIRCULAR (NO. 2024-03)

Subject:

Notice of Amendment to Kuwait Civil Aviation Safety Regulations KCASR (issue 4).

Purpose:

The purpose of this Regulatory Circular No. **2024-03** is to Amend **PERSONNEL LICENSINGPART MED – ACCEPTABLE MEANS OF COMPLIANCE (AMC) & GUIDANCE MATERIALS (GM)** (issue 4) to comply with DGCA requirmants.

This Regulatory Circular No.**2024-03** is based on (NPA) No. 2024-02 dated 20/Feb/2024

Revisions:

This amendment will be included in the revision (**4**) of PERSONNEL LICENSINGPART MED – ACCEPTABLE MEANS OF COMPLIANCE (AMC) & GUIDANCE MATERIALS (GM).

Regulatory Requirements:

This amendment shall apply to the following Organizations approved by the Directorate General of Civil Aviation (DGCA) or authorised to operate within the State of Kuwait:

1. Airport Operators;
2. Air Navigation Service Providers;
3. Air Operator Certificate (AOC);
4. Approved Maintenance Organizations (AMO) Holders;
5. Ground Handling Service Providers;
6. Flying Training Organizations;
7. All users of KCASRs.

Effective Date:

This new revision will be in effect from **02/Jun/2024**.

Required Action:

All users of KCASR must comply with the provisions of this amendment from the effective date.

✓ **President of Civil Aviation**

Abdullah F. Alrajhi
Acting / Deputy Director General
for Aviation Safety, Air Transport & Aviation Security

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الطيران المدني
Civil Aviation
State of Kuwait - دولـة الكويـت

Kuwait Civil Aviation Safety Regulations

KCASR 1 – PERSONNEL LICENSING

PART MED – ACCEPTABLE MEANS OF COMPLIANCE (AMC) & GUIDANCE MATERIALS (GM)

Table of Contents

Table of Contents 2
Amendment Record 7
Control of this Document 8
DC.3 Applicability 8
DC.4 Scope 8
DC.5 Definitions 8
Abbreviations & Acronyms 8
SARPs Standards and Recommended Practices Subpart A - General Requirements 9
Section 1 General 9
AMC1 MED.A.015 Medical confidentiality 9
GM1 MED.A.020 Decrease in medical fitness 9
AMC1 MED.A.025 Obligations of the AeMC and AME 12
GM1 MED.A.025 Obligations of the AeMC or AME 12
Section 2 – Requirements for medical certificates 15
AMC1 MED.A.030 Medical certificates 15
AMC1 MED.A.035 Application for a medical certificate 15
AMC1 MED.A.045 Validity, revalidation and renewal of medical certificates 15
Subpart B - Specific requirements for 16
Pilot Medical Certificates 16
Section 1 - General 16
AMC1 MED.B.001 Limitations to medical certificates 16
AMC2 MED.B.001 Limitation codes 17
Section 2 - Medical Requirements for Class 1 and Class 2 Medical Certificates 20
1. Class One 20
AMC1 MED.B.010 Cardiovascular system 20
GM1 MED.B.010 Cardiovascular system 27
GM2 MED.B.010 Cardiovascular system 28
AMC1 MED.B.015 Respiratory system 28
AMC1 MED.B.020 Digestive system 29
AMC1 MED.B.025 Metabolic and Endocrine systems 30
AMC1 MED.B.030 Haematology 31
AMC1 MED.B.035 Genitourinary system 33
AMC1 MED.B.040 Infectious disease 34
AMC1 MED.B.045 Obstetrics and gynaecology 34

AMC1 MED.B.050 Musculoskeletal system 34
AMC1 MED.B.055 (Mental Health) 35
AMC2 MED.B.055 Mental health 38
GM1 MED.B.055 Mental health 40
GM2 MED.B.055 Mental health 41
AMC1 MED.B.060 Psychology 41
AMC1 MED.B.065 Neurology 42
AMC1 MED.B.070 Visual system 43
AMC1 MED B.075 Colour vision 47
AMC1 MED.B.080 Otorhino-laryngology 47
AMC1 MED.B.085 Dermatology 49
AMC1 MED.B.090 Oncology 49
2. Class Two 50
AMC2 MED.B.010 Cardiovascular system 50
AMC2 MED.B.015 Respiratory system 55
AMC2 MED.B.020 Digestive system 56
AMC2 MED.B.025 Metabolic and endocrine systems 57
AMC2 MED.B.030 Haematology 58
AMC2 MED.B.035 Genitourinary system 59
AMC2 MED.B.040 Infectious disease 59
AMC2 MED.B.045 Obstetrics and gynaecology 60
AMC2 MED.B.050 Musculoskeletal system 60
AMC2 MED.B.055 Mental Health 60
GM1 MED.B.055 Mental health 62
GM2 MED.B.055 Mental health 62
AMC2 MED.B.060 Psychology 63
AMC2 MED.B.065 Neurology 63
AMC2 MED.B.070 Visual system 64
AMC2 MED B.075 Colour vision 65
AMC2 MED.B.080 Otorhino-laryngology 66
AMC2 MED.B.085 Dermatology 67
AMC MED.B.090 Oncology 67
Section 3 - Specific Requirements for LAPL Medical Certificates 68
AMC1 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates 68

AMC2 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Cardiovascular system) 68

AMC3 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Respiratory system) 69

AMC4 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Digestive system) 70

AMC5 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Metabolic and endocrine systems) 70

GM1 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Diabetes mellitus Type 2 treated with insulin) 73

AMC6 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Haematology) 73

AMC7 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Genitourinary system) 73

AMC8 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Infectious disease) 73

AMC9 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Obstetrics and gynaecology) 74

AMC10 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Musculoskeletal system) 74

AMC11 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Psychiatry) Mental health 74

(Psychology) 74

AMC12 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Neurology) 75

AMC13 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Visual system) 76

AMC14 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Colour vision) 76

AMC15 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Otorhino-laryngology) 77

AMC16 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Dermatology) 77

AMC17 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Oncology) 77

Subpart C - Requirements for Medical Fitness of Cabin Crew 79

Section 1 - General requirements 79

AMC1 MED.C.005 Aero-medical assessments 79

Section 2 - Requirements for aero-medical assessment of cabin crew 80

AMC1 MED.C.025 Content of aero-medical assessments 80

AMC2 MED.C.025 Content of aero-medical assessments (Cardiovascular system) 80
AMC3 MED.C.025 Content of aero-medical assessments (Respiratory system) 82
AMC4 MED.C.025 Content of aero-medical assessments (Digestive system) 82
AMC5 MED.C.025 Content of aero-medical assessments (Metabolic and endocrine systems) 83
AMC6 MED.C.025 Content of aero-medical assessments (Haematology) 83
AMC7 MED.C.025 Content of aero-medical assessments (Genitourinary system) 84
AMC8 MED.C.025 Content of aero-medical assessments 84
AMC9 MED.C.025 Content of aero-medical assessments (Obstetrics and gynaecology) ... 84
AMC10 MED.C.025 Content of aero-medical assessments (Musculoskeletal system) 85
AMC11 MED.C.025 Content of aero-medical assessments Mental Health 85
AMC12 MED.C.025 Content of aero-medical assessments (Neurology) 86
AMC13 MED.C.025 Content of aero-medical assessments (Visual System) 87
AMC14 MED.C.025 Content of aero-medical assessments (Colour vision) 87
AMC15 MED.C.025 Content of aero-medical assessments (Otorhino-laryngology) 87
AMC16 MED.C.025 Content of aero-medical assessments (Dermatology) 88
AMC17 MED.C.025 Content of aero-medical assessments (Oncology) 88
GM1 MED.C.025 Content of aero-medical assessments 88
Section 3 - Additional Requirements for Applicants for, and Holders of, a Cabin Crew Attestation 91
AMC1 MED.C.030 Cabin crew medical report 91
AMC1 MED.C.035 Limitations 91
Subpart D - Aero-Medical Examiners (AMEs) 93
AMC1 MED.D.010 Requirements for the issue of an AME certificate 93
AMC1 MED.D.015 Requirements for the extension of privileges 94
AMC1 MED.D.030 Validity of AME certificates 94
Refresher training in aviation medicine 94
Subpart E - Medical Requirements for Air Traffic Controllers 96
GM1 MED.A.020 Decrease in medical fitness 96
AMC1 MED.A.035 Application for a medical certificate 99
AMC1 MED.E.006 Limitations to medical certificates 99
AMC2 MED.E.006 Limitations to medical certificates 99
AMC1 MED.E.010 Cardiovascular system 102
GM1 MED.E.010 Cardiovascular system 108
GM2 MED.E.010 Cardiovascular system 109
GM3 MED.E.010 Cardiovascular system 109

GM4 MED.E.010 Cardiovascular system 109
GM5 MED.E.010 Cardiovascular system 109
AMC1 MED.E.015 Respiratory system 110
AMC1 MED.E.020 Digestive system 111
AMC1 MED.E.025 Metabolic , Nutritional and endocrine system 112
AMC1 MED.E.030 Haematology 113
GM1 MED.E.030 Haematology 113
GM2 MED.E.030 Haematology 114
GM3 MED.E.030 Haematology 114
AMC1 MED.E.035 Urinary system 114
AMC1 MED.E.040 Infectious diseases 115
AMC1 MED.E.045 Obstetrics and gynaecology 115
AMC1 MED.E.050 Musculoskeletal system 116
AMC1 MED.E.055 Psychiatry 116
AMC1 MED.E.60 Psychology 117
AMC1 MED.E.65 Neurology 117
AMC1 MED.E.070 Visual system 118
GM1 MED.E.070 Visual system 122
AMC1 MED.E.075 Colour vision 122
GM1 MED.E.075 Colour vision 122
AMC1 MED.E.080 Otorhinolaryngology 123
GM1 MED.E.080 Otorhinolaryngology 123
AMC1 MED.E.090 Dermatology 124
AMC1 MED.E.095 Oncology 124
Appendix I : Alcohol And Substance Abuse Prevention Policy 126

Amendment Record

Amendment No	Date of Issue	Remarks
1	June 2018	Part Rename
2	September 2018	Reg Circular 2018-24 (DGCA Requirements) NPA 2018-22
3	July 2019	Reg Cir 2019-25 (NPA 2019-12)
4	April 2024	NPA 2024-02 Inline with EASA (Aug 2023)

Control of this Document

DC.1 Introduction

DC.1.1 Pursuant to Law No (30) of the year 1960 and subsequent Ministerial Decisions No (3) of the year 1986 and No (18) of the year 1996, based upon that Law and as reflected in the Preamble to the Kuwait Civil Aviation Safety Regulations, Issue 4, Rev.2, August 2019, the President of the Kuwait Directorate General of Civil Aviation is empowered to adopt and amend Kuwait Civil Aviation Safety Regulations. In accordance herewith, the following AMC & GM is hereby established for compliance by all persons concerned. This AMC & GM shall be known as KCASR Part 1 – Part MED Medical AMC &GM and any reference to this title shall mean referring to these regulations governing the requirements to be met for the certification of personnel licensing.

DC.2 Authority for this Regulation

DC.2.1 This KCASR Part 1 – Part MED Medical AMC &GM is issued on the authority of the President of the Kuwait Directorate General of Civil Aviation.

DC.3 Applicability

DC.3.1 This KCASR Part 1 – Part MED Medical AMC &GM is applicable to the aviation industry of the State of Kuwait.

DC.4 Scope

DC.4.1 KCASR Part 1 Personnel Licencing AMC & GM contains the acceptable means of compliance and guidance material for the personnel licensing regulations and shows compliance with ICAO Annex 1. The AMC & GM are separated into the following parts with cross references between parts where applicable.

- Part ARA Authority Requirements for Aircrew AMC & GM
- Part ORA Organisational Requirements for Aircrew AMC & GM
- Part FCL Flight Crew Licensing AMC & GM
- Part CC Cabin Crew AMC & GM
- Part FOO/FD Flight Operation Officer and Flight Dispatcher AMC & GM
- **Part MED Medical AMC & GM**
- Part 66 Aircraft Maintenance Engineer Licence AMC & GM
- Part 147 Approved Training Organisations AMC & GM
- Part ATCO Air Traffic Control Officer AMC & GM

DC.5 Definitions

DC.5.1 Terms not defined shall have the meaning given to them in the relevant legal instruments or international legal instruments in which they appear, especially as they appear in the Convention and its Annexes.

Abbreviations & Acronyms

ATS	Air traffic services
ICAO	International Civil Aviation Organisation
DGCA	Kuwait Civil Aviation Authority DGCA Directorate General of Civil Aviation
KCASRs	Kuwait Civil Aviation Safety Regulations

SARPs Standards and Recommended Practices
Subpart A - General Requirements

Section 1 General

AMC1 MED.A.015 Medical confidentiality

To ensure medical confidentiality, all medical reports and records should be securely held with accessibility restricted to personnel authorised by the medical assessor or, where applicable, by the head of the aero-medical centre (AEMC) or the aero-medical examiner (AME).

GM1 MED.A.020 Decrease in medical fitness

MEDICATION — GUIDANCE FOR PILOTS AND CABIN CREW MEMBERS

(a) Any medication can cause side effects, some of which may impair the safe performance of flying duties. Equally, symptoms of colds, sore throats, diarrhoea and other abdominal upsets may cause little or no problem whilst on the ground but may distract the pilot or cabin crew member and degrade their performance whilst on duty. The in-flight environment may also increase the severity of symptoms which may only be minor whilst on the ground. Therefore, one issue with medication and flying is the underlying condition and, in addition, the symptoms may be compounded by the side effects of the medication prescribed or bought over the counter for treatment. This guidance material provides some help to pilots and cabin crew in deciding whether expert aero-medical advice by an AME, AeMC or Kuwait DGCA medical assessor is needed.

(b) Before taking any medication and acting as a pilot or cabin crew member, the following three basic questions should be satisfactorily answered:

(1) Do I feel fit to fly?

(2) Do I really need to take medication at all?

(3) Have I given this particular medication a personal trial on the ground to ensure that it will not have any adverse effects on my ability to fly?

(c) Confirming the absence of adverse effects may well need expert aero-medical advice.

(d) The following are some widely used medicines with a description of their compatibility with flying duties:

(1) Antibiotics. Antibiotics may have short-term or delayed side effects which can affect pilot or cabin crew performance. More significantly, however, their use usually indicates that an infection is present and, thus, the effects of this infection may mean that a pilot or cabin crew member is not fit to fly and should obtain expert aero-medical advice.

(2) Anti-malaria drugs. The decision on the need for anti-malaria drugs depends on the geographical areas to be visited, and the risk that the pilot or cabin crew member has of

being exposed to mosquitoes and of developing malaria. An expert medical opinion should be obtained to establish whether anti-malaria drugs are needed and what kind of drugs should be used. Most of the anti-malaria drugs (atovaquone plus proguanil, chloroquine, doxycycline) are compatible with flying duties. However, adverse effects associated with mefloquine include insomnia, strange dreams, mood changes, nausea, diarrhoea and headaches. In addition, mefloquine may cause spatial disorientation and lack of fine coordination and is, therefore, not compatible with flying duties.

(3) Antihistamines. Antihistamines can cause drowsiness. They are widely used in 'cold cures' and in treatment of hay fever, asthma and allergic rashes. They may be in tablet form or a constituent of nose drops or sprays. In many cases, the condition itself may preclude flying, so that, if treatment is necessary, expert aero-medical advice should be sought so that so-called non-sedative antihistamines, which do not degrade human performance, can be prescribed.

(4) Cough medicines. Antitussives often contain codeine, dextromethorfan or pseudo-ephedrine which are not compatible with flying duties. However, mucolytic agents (e.g. carbocysteine) are well-tolerated and are compatible with flying duties.

(5) Decongestants. Nasal decongestants with no effect on alertness may be compatible with flying duties. However, as the underlying condition requiring the use of decongestants may be incompatible with flying duties, expert aero-medical advice should be sought. For example, oedema of the mucosal membranes causes difficulties in equalising the pressure in the ears or sinuses.

(6) Nasal corticosteroids are commonly used to treat hay fever, and they are compatible with flying duties.

(i) Common pain killers and antifebrile drugs. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and paracetamol, commonly used to treat pain, fever or headaches, may be compatible with flying duties. However, the pilot or cabin crew member should give affirmative answers to the three basic questions listed in (b) before using the medication and carrying out flying duties.

(ii) Strong analgesics. The more potent analgesics including codeine are opiate derivatives, and may produce a significant decrement in human performance and, therefore, are not compatible with flying duties.

(7) Anti-ulcer medicines. Gastric secretion inhibitors such as H2 antagonists (e.g. ranitidine, cimetidine) or proton pump inhibitors (e.g. omeprazole) may be acceptable after diagnosis of the pathological condition. It is important to seek for the medical diagnosis and not to only treat the dyspeptic symptoms.

(8) Anti-diarrhoeal drugs. Loperamide is one of the more common anti-diarrhoeal drugs and is usually safe to take whilst flying. However, the diarrhoea itself often makes the pilot and cabin crew member unfit for flying duties.

(9) Hormonal contraceptives and hormone replacement therapy usually have no adverse effects and are compatible with flying duties.

(10) Erectile dysfunction medication. This medication may cause disturbances in colour vision and dizziness. There should be at least 6 hours between taking sildenafil and flying duty; and 36 hours between taking vardenafil or tadalafil and flying duty.

(11) Smoking cessation. Nicotine replacement therapy may be acceptable. However, other medication affecting the central nervous system (buproprion, varenicline) is not acceptable for pilots.

(12) High blood pressure medication. Most anti-hypertensive drugs are compatible with flying duties However, if the level of blood pressure is such that drug therapy is required, the pilot or cabin crew member should be monitored for any side effects before carrying out flying duties. Therefore, consultation with the AME, AeMC, or Kuwait DGCA medical assessor as applicable, is needed.

(13) Asthma medication. Asthma has to be clinically stable before a pilot or cabin crew member can return to flying duties. The use of respiratory aeroZols or powders, such as corticosteroids, beta-2-agonists or chromoglycic acid may be compatible with flying duties. However, the use of oral steroids or theophylline derivatives is incompatible with flying duty. Pilots or cabin crew members using medication for asthma should consult the AME, AeMC, or medical assessor, as applicable.

(14) Tranquillisers and sedatives. The inability to react, due to the use of this group of medicines, has been a contributory cause to fatal aircraft accidents. In addition, the underlying condition for which these medications have been prescribed will almost certainly mean that the mental state of a pilot or cabin crew member is not compatible with flying duties.

(15) Sleeping tablets. Sleeping tablets dull the senses, may cause confusion and slow reaction times. The duration of effect may vary from individual to individual and may be unduly prolonged. Expert aero-medical advice should be obtained before using sleeping tablets.

(16) Melatonin. Melatonin is a hormone that is involved with the regulation of the circadian rhythm. In some countries it is a prescription medicine, whereas in most other countries it is regarded as a ‘dietary supplement’ and can be bought without any prescription. The results from the efficiency of melatonin in treatment of jet lag or sleep disorders have been contradictory. Expert aero-medical advice should be obtained.

(17) Coffee and other caffeinated drinks may be acceptable, but excessive coffee drinking may have harmful effects, including disturbance of the heart’s rhythm. Other stimulants including caffeine pills, amphetamines, etc. (often known as ‘pep’ pills) used to maintain wakefulness or suppress appetite can be habit forming. Susceptibility to different stimulants varies from one individual to another, and all may cause dangerous overconfidence. Overdosage causes headaches, dizziness and mental disturbance. These other stimulants should not be used.

(18) Anaesthetics. Following local, general, dental and other anaesthetics, a period of time should elapse before returning to flying. The period will vary considerably from individual to individual, but a pilot or cabin crew member should not fly for at least 12 hours after a local anaesthetic, and for at least 48 hours after a general, spinal or epidural anaesthetic.

(e) Many preparations on the market nowadays contain a combination of medicines. It is, therefore, essential that if there is any new medication or dosage, however slight, the effect should be observed by the pilot or the cabin crew member on the ground prior to flying. It should be noted that medication which would not normally affect pilot or cabin crew performance may do so in individuals who are ‘oversensitive’ to a particular preparation. Individuals are, therefore, advised not to take any medicines before or during flight unless they are completely familiar with their effects on their own bodies. In cases of doubt, pilots and cabin crew members should consult an AME, AeMC, or Kuwait DGCA medical assessor, as applicable.

(f) Other treatments

Alternative or complementary medicine, such as acupuncture, homeopathy, hypnotherapy and several other disciplines, is developing and gaining greater credibility. Such treatments are more acceptable in some States than others. There is a need to ensure that 'other treatments', as well as the underlying condition, are declared and considered by the AME, AeMC, or Kuwait DGCA medical assessor, as applicable, for assessing fitness.

AMC1 MED.A.025 Obligations of the AeMC and AME

(a) If the medical examination is carried out by two or more AMEs, only one of them should be responsible for coordinating the results of the examination, evaluating the findings with regard to medical fitness, and signing the report.

(b) The applicant should be made aware that the associated medical certificate or cabin crew report may be suspended or revoked if the applicant provides incomplete, inaccurate or false statements on their medical history to the AeMC or AME.

(c) In cases where the AeMC or AME is required to assess the fitness of an applicant for a class 2 medical certificate in consultation with the medical assessor of the DGCA/ASD, they should document the consultation in accordance with the procedure established by the DGCA/ASD.

(d) The AeMC or AME should give advice to the applicant on treatment and preventive measures if, during the course of the examination, medical conditions or risk factors are identified which may endanger the medical fitness of the applicant in the future.

(e) In case of denial or referral to the licensing authority, the AeMC or AME should inform the applicant in writing regarding the result of the assessment in a form and manner established by the competent authority.

GM1 MED.A.025 Obligations of the AeMC or AME

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GUIDELINES FOR THE AeMC OR AME CONDUCTING THE MEDICAL EXAMINATIONS AND ASSESSMENTS FOR MEDICAL CERTIFICATION OF PILOTS

(a) Before performing the medical examination, the AeMC, or AME should:

(1) verify the applicant's identity by checking their passport, or other official document containing a photograph of the applicant;

(2) obtain details of the applicant's flight crew licence from the applicant's licensing authority if they do not have their licence with them;

(3) except for initial applicants, obtain details of the applicant's most recent medical certificate from the medical assessor of the applicant's licensing authority if they do not have their certificate with them;

(4) in the case of a specific medical examination(s) (SIC) limitation on the existing medical certificate, obtain details of the specific medical condition and any associated instructions from the medical assessor of the applicant's licensing authority. This could include, for example, a requirement to undergo a specific examination or test;

(5) except for initial applicants, ascertain, from the previous medical certificate, which routine medical test(s) should be conducted, for example electrocardiography (ECG);

(6) provide the applicant with the application form for a medical certificate and the instructions for completion and ask the applicant to complete the form but not to sign it yet;

(7) go through the form with the applicant and give information to help the applicant understand the significance of the entries and ask any questions which might help the applicant to recall important historical medical data;

(8) verify that the form is complete and legible, ask the applicant to sign and date the form and then sign it as well. If the applicant declines to complete the application form fully, inform the applicant that it may not be possible to issue a medical certificate regardless of the outcome of the clinical examination and assessment.

(b) Once all the items in (a) have been addressed, the AeMC or AME should:

(1) perform the medical examination of the applicant in accordance with the applicable rules;

(2) arrange for additional specialist medical examinations, such as otorhinolaryngology (ENT) or ophthalmology, to be conducted as applicable and obtain the associated report forms or reports;

(3) complete the medical examination report form in accordance with the associated instructions for completion;

(4) ensure that all of the report forms are complete, accurate and legible.

(c) Once all the actions in (b) have been carried out, the AeMC or AME should review the report forms and:

(1) if satisfied that the applicant meets the applicable medical requirements as set out in Part-MED, issue a medical certificate for the appropriate class, with limitations if necessary. The applicant should sign the certificate once signed by the AeMC or AME; or

(2) if the applicant does not meet the applicable medical requirements, or if the fitness of the applicant for the class of medical certificate applied for is in doubt:

(i) refer the decision on medical fitness to, or consult the decision on medical fitness with, the medical assessor of the licensing authority or AME in compliance with MED.B.001; or

(ii) deny issuance of a medical certificate, explain the reason(s) for denial to the applicant and inform them of their right of a review according to the procedures of the competent authority.

(d) The AeMC or AME should send the documents as required by MED.A.025(b) to the medical assessor of the applicant's licensing authority within 5 days from the date of the medical examination. If a medical certificate has been denied or the decision has been referred, the documents should be sent to the medical assessor of the licensing authority on the same day that the denial or referral decision is reached.

Section 2 – Requirements for medical certificates

AMC1 MED.A.030 Medical certificates

(a) A class 1 medical certificate includes the privileges and validities of class 2 and LAPL, SPL, BPL, LSA medical certificates.

(b) A class 2 medical certificate includes the privileges and validities of a LAPL, SPL, BPL, LSA medical certificate.

(c) A class 3 medical certificate is only valid for ATCOs.

AMC1 MED.A.035 Application for a medical certificate

When applicants do not present a current or previous medical certificate to the AeMC or AME prior to the relevant examinations, the AeMC or AME should not issue the medical certificate unless relevant information is received from Kuwait DGCA/ASD.

AMC1 MED.A.045 Validity, revalidation and renewal of medical certificates

The validity period of a medical certificate (including any associated examination or special investigation) is determined by the age of the applicant at the date of the medical examination.

Subpart B - Specific requirements for

Pilot Medical Certificates

Section 1 - General

AMC1 MED.B.001 Limitations to medical certificates

(a) An AeMC or AME may refer the decision on fitness of the applicant to the Kuwait DGCA in borderline cases or where fitness is in doubt.

(b) In cases where a fit assessment can only be considered with a limitation, the AeMC, AME or the Kuwait DGCA should evaluate the medical condition of the applicant in consultation with flight operations and other experts, if necessary.

(c) Limitation codes:

	Code	Limitation
1	TML	restriction of the period of validity of the medical certificate to:
2	VDL	Wear corrective lenses for distance vision and carry a spare set of spectacles
3	VNL	Having available corrective spectacles for near vision and carry a spare set of spectacles
4	VML	Wear multifocal spectacles and carry a spare set of spectacles for correction for defective distant, intermediate and near vision
5	OML	valid only as or with qualified co-pilot (for class one only)
6	VCL	valid by day only (class two only)
7	OSL	Valid only with safety pilot and in aircraft with dual controls (class two and LAPL)
8	APL	valid only with approved prosthesis (class two only)
9	OCL	valid only as co-pilot (class one Only)
10	OPL	valid only without passengers (PPL and LAPL only)
11	SSL	special restriction as specified (LAPL)
	ILA	Issued by Kuwait DGCA in accordance with MED.B.001
	AGL	Valid only with approved eye protection
	AMS	To be issued by AMC only
	AUD	Annual Audiogram Required
	ALT 6	Flight not above 6000 feet above mean sea level

	FWO	Valid for fixed wing aircraft only
	CLT	Valid for centre line thrust aircraft only
	FHA	Function hearing assessment required within 3 months of renewal/revalidation medical
12	OAL	restricted to demonstrated aircraft type (class two only)
13	AHL	valid only with approved hand controls (class two only)
14	SIC	specific regular medical examination(s) - contact the Kuwait DGCA
15	RXO	specialist ophthalmological examinations (ATCO or Class TWO)
16	HAL	valid only when hearing aids are worn
17	ORL	Valid only with a safety pilot if passengers are carried (class two only)

(d) Entry of limitations

(1) Limitations 1 to 4 may be imposed by an AME or an AeMC.

(2) Limitations 5 to 17 should only be imposed:

(i) for class 1 medical certificates by the Kuwait DGCA;

(ii) for class 2 medical certificates by the AME or AeMC in consultation with the Kuwait DGCA;

(iii) for LAPL medical certificates by an AME or AeMC.

(e) Removal of limitations

(1) For class 1 medical certificates, all limitations should only be removed by the Kuwait DGCA .

(2) For class 2 medical certificates, limitations may be removed by the Kuwait DGCA or by an AeMC or AME in consultation with the Kuwait DGCA.

(3) For LAPL medical certificates, limitations may be removed by an AeMC or AME.

AMC2 MED.B.001 Limitation codes

(1) TML Time limitation

The period of validity of the medical certificate is limited to the duration as shown on the medical certificate. This period of validity commences on the date of the medical examination. Any period of validity remaining on the previous medical certificate is no longer valid. The pilot should present him/herself for re-examination when advised and should follow any medical recommendations.

(2) VDL Wear corrective lenses and carry a spare set of spectacles

Correction for defective distant vision: whilst exercising the privileges of the licence, the pilot should wear spectacles or contact lenses that correct for defective distant vision as examined and approved by the AME. Contact lenses may not be worn until cleared to do so by the AME. If contact lenses are worn, a spare set of spectacles, approved by the AME, should be carried.

(3) VNL Have available corrective spectacles and carry a spare set of spectacles

Correction for defective near vision: whilst exercising the privileges of the licence, the pilot should have readily available spectacles that correct for defective near vision as examined and approved by the AME. Contact lenses or full frame spectacles, when either correct for near vision only, may not be worn.

(4) VML Wear multifocal spectacles and carry a spare set of spectacles

Correction for defective distant, intermediate and near vision: whilst exercising the privileges of the licence, the pilot should wear spectacles that correct for defective distant, intermediate and near vision as examined and approved by the AME. Contact lenses or full frame spectacles, when either correct for near vision only, may not be worn.

(5) OML Valid only as or with qualified co-pilot

This applies to crew members who do not meet the medical requirements for single crew operations, but are fit for multi-crew operations. Applicable to class 1 medical certificates only.

(6) VCL Valid by day only

The limitation allows private pilots with varying degrees of colour deficiency to exercise the privileges of their licence by daytime only. Applicable to class 2 medical certificates only.

(7) OCL Valid only as co-pilot

This limitation is a further extension of the OML limitation and is applied when, for some well-defined medical reason, the pilot is assessed as safe to operate in a co-pilot role but not in command. Applicable to class 1 medical certificates only applies to crew members who do not meet the medical requirements for single crew operations, but are fit for multi-crew operations. Applicable to class 1 medical certificates only.

(8) APL Valid only with approved prosthesis

This limitation applies to the holder of a medical certificate with a musculoskeletal condition when a medical flight test or a flight simulator test has shown that the use of a prosthesis is required to safely exercise the privileges of the licence. The prosthesis to be used should be approved.

(9) OSL Valid only with safety pilot and in aircraft with dual controls

The safety pilot is qualified as PIC on the class/type of aircraft and rated for the flight conditions. He/she occupies a control seat, is aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and is prepared to take over the aircraft controls during flight. Applicable to class 2 and LAPL medical certificates only.

(10) OPL Valid only without passengers

This limitation may be considered when a pilot with a musculoskeletal problem, or some other medical condition, may involve an increased element of risk to flight safety which might be acceptable to the pilot but which is not acceptable for the carriage of passengers. Applicable to class 2 and LAPL medical certificates only.

(11) SSL Special restriction(s) as specified

This limitation may be considered when an individually specified limitation, not defined in this AMC, is appropriate to mitigate an increased level of risk to flight safety. The description of the SSL should be entered on the medical certificate or in a separate document to be carried with the medical certificate.

(12) OAL Restricted to demonstrated aircraft type

This limitation may apply to a pilot who has a limb deficiency or some other anatomical problem which had been shown by a medical flight test or flight simulator testing to be acceptable but to require a restriction to a specific type of aircraft.

(13) AHL Valid only with approved hand controls

This limitation applies to the holder of a medical certificate who has a limb deficiency or other anatomical problem which had been shown by a medical flight test or flight simulator testing to be acceptable but to require the aircraft to be equipped with suitable, approved hand controls.

(14) SIC Specific regular medical examination(s) contact the Kuwait DGCA

This limitation requires the AME to contact the Kuwait DGCA before embarking upon renewal or recertification medical assessment. It is likely to concern a medical history of which the AME should be aware prior to undertaking the assessment.

(15) RXO Specialist ophthalmological examinations

Specialist ophthalmological examinations are required for a significant reason. The limitation may be applied by an AME but should only be removed by the Kuwait DGCA.

(16) HAL valid only when hearing aids are worn

(17) ORL Valid only with a safety pilot if passengers are carried (class two only)This limitation applies to holders of a class 2 or LAPL medical certificate with a medical condition that may lead to an increased level of risk to flight safety when exercising the privileges of the licence. The safety pilot, if carried, should be made aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and should be prepared to take over the aircraft controls during flight

Section 2 - Medical Requirements for Class 1 and Class 2 Medical Certificates

1. Class One

AMC1 MED.B.010 Cardiovascular system

(a) Examination

Exercise electrocardiography

An exercise ECG when required as part of a cardiovascular assessment should be symptom limited and completed to a minimum of Bruce Stage IV or equivalent.

(b) General

(1) Cardiovascular risk factor assessment

(i) Serum lipid estimation is case finding and significant abnormalities should require review, investigation and supervision by the AeMC or AME in consultation with the Kuwait DGCA.

(ii) An accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) should require cardiovascular evaluation by the AeMC or AME in consultation with the Kuwait DGCA.

(2) Cardiovascular assessment

(i) Reporting of resting and exercise electrocardiograms should be by the AME or an accredited specialist.

(ii) The extended cardiovascular assessment should be undertaken at an AeMC or may be delegated to a cardiologist.

(c) Peripheral arterial disease

If there is no significant functional impairment, a fit assessment may be considered by the Kuwait DGCA, provided:

(1) applicants without symptoms of coronary artery disease have reduced any vascular risk factors to an appropriate level;

(2) applicants should be on acceptable secondary prevention treatment;

(3) exercise electrocardiography is satisfactory. Further tests may be required which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(d) Aortic aneurysm

(1) Applicants with an aneurysm of the infra-renal abdominal aorta may be assessed as fit with a multi-pilot limitation by the Kuwait DGCA. Follow-up by ultra-sound scans or other imaging techniques, as necessary, should be determined by the Kuwait DGCA.

(2) Applicants may be assessed as fit by the Kuwait DGCA after surgery for an infra-renal aortic aneurysm with a multi-pilot limitation at revalidation if the blood pressure and cardiovascular assessment are satisfactory. Regular cardiological review should be required.

(e) Cardiac valvular abnormalities

(1) Applicants with previously unrecognised cardiac murmurs should undergo evaluation by a cardiologist and assessment by the Kuwait DGCA. If considered significant, further investigation should include at least 2D Doppler echocardiography or equivalent imaging.

(2) Applicants with minor cardiac valvular abnormalities may be assessed as fit by the Kuwait DGCA. Applicants with significant abnormality of any of the heart valves should be assessed as unfit.

(3) Aortic valve disease:

(i) Applicants with a bicuspid aortic valve may be assessed as fit if no other cardiacor aortic abnormality is demonstrated. Follow-up with echocardiography, as necessary, should be determined by the Kuwait DGCA.

(A) Applicants with aortic stenosis require the Kuwait DGCA review. Left ventricular function should be intact. A history of systemic embolism or significant dilatation of the thoracic aorta is disqualifying. Those with a mean pressure gradient of up to 20 mmHg may be assessed as fit. Those with mean pressure gradient above 20 mmHg but not greater than 40 mmHg may be assessed as fit with a multi-pilot limitation. A mean pressure gradient up to 50 mmHg may be acceptable. Follow-up with 2D Doppler echocardiography, as necessary, should be determined by the Kuwait DGCA. Alternative measurement techniques with equivalent ranges may be used.

(ii) Applicants with trivial aortic regurgitation may be assessed as fit. A greater degree of aortic regurgitation should require a multi-pilot limitation. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Follow-up, as necessary, should be determined by the Kuwait DGCA.

(4) Mitral valve disease

(i) Asymptomatic applicants with an isolated mid-systolic click due to mitral leaflet prolapse may be assessed as fit.

(A) Applicants with rheumatic mitral stenosis should normally be assessed as unfit.

(B) Applicants with uncomplicated minor regurgitation may be assessed as fit.

(C) Periodic cardiological review should be determined by the Kuwait DGCA.

(D) Applicants with uncomplicated moderate mitral regurgitation may be considered as fit with a multi-pilot limitation if the 2D Doppler echocardiogram demonstrates satisfactory left ventricular dimensions and satisfactory myocardial function is confirmed by exercise electrocardiography. Periodic cardiological review should be required, as determined by the Kuwait DGCA.

(E) Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter or evidence of systolic impairment should be assessed as unfit.

(f) Valvular surgery

Applicants with cardiac valve replacement/repair should be assessed as unfit. A fit assessment may be considered by the Kuwait DGCA.

(1) Aortic valvotomy should be disqualifying.

(2) Mitral leaflet repair for prolapse is compatible with a fit assessment, provided post- operative investigations reveal satisfactory left ventricular function without systolic or diastolic dilation and no more than minor mitral regurgitation.

(3) Asymptomatic applicants with a tissue valve or with a mechanical valve who, at least 6 months following surgery, are taking no cardioactive medication may be considered for a fit assessment with a multi-pilot limitation by the Kuwait DGCA. Investigations which demonstrate normal valvular and ventricular configuration and function should have been completed as demonstrated by:

(i) a satisfactory symptom limited exercise ECG. Myocardial perfusion imaging/stress echocardiography should be required if the exercise ECG is abnormal or any coronary artery disease has been demonstrated;

(ii) a 2D Doppler echocardiogram showing no significant selective chamber enlargement, a tissue valve with minimal structural alteration and a normal Doppler blood flow, and no structural or functional abnormality of the other heart valves. Left ventricular fractional shortening should be normal.

(iii) Follow-up with exercise ECG and 2D echocardiography, as necessary, should be determined by the Kuwait DGCA.

(4) Where anticoagulation is needed after valvular surgery, a fit assessment with a multi-pilot limitation may be considered after review by the Kuwait DGCA. The review should show that the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.

(g) Thromboembolic disorders

Applicant with arterial or venous thrombosis or pulmonary embolism are disqualifying whilst anticoagulation is being used as treatment. After 6 months of stable anticoagulation as prophylaxis, a fit assessment with multi-pilot limitation may be considered after review by the Kuwait DGCA. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. Pulmonary embolus should require full evaluation. Following cessation of anti-coagulant therapy, for any indication, applicants should require review by the Kuwait DGCA.

(h) Other cardiac disorders

(1) Applicants with a primary or secondary abnormality of the pericardium, myocardium or endocardium should be assessed as unfit. A fit assessment may be considered by the Kuwait DGCA following complete resolution and satisfactory cardiological evaluation which may include 2D Doppler echocardiography, exercise ECG and/or myocardial perfusion imaging/stress echocardiography and 24-hour ambulatory ECG. Coronary angiography may be indicated. Frequent review and a multi-pilot limitation may be required after fit assessment.

(2) Applicants with a congenital abnormality of the heart, including those who have undergone surgical correction, should be assessed as unfit. Applicants with minor abnormalities that are functionally unimportant may be assessed as fit by the Kuwait DGCA following cardiological assessment. No cardioactive medication is acceptable. Investigations may include 2D Doppler echocardiography, exercise ECG and 24-hour ambulatory ECG. Regular cardiological review should be required.

(i) Syncope

(1) In the case of a single episode of vasovagal syncope which can be explained and is compatible with flight safety, a fit assessment may be considered.

(2) Applicants with a history of recurrent vasovagal syncope should be assessed as unfit. A fit assessment may be considered by the Kuwait DGCA after a 6-month period without recurrence provided cardiological evaluation is satisfactory. Such evaluation should include:

(i) a satisfactory symptom limited 12 lead exercise ECG to Bruce Stage IV or equivalent. If the exercise ECG is abnormal, myocardial perfusion imaging/stress echocardiography should be required;

(ii) a 2D Doppler echocardiogram showing neither significant selective chamber enlargement nor structural or functional abnormality of the heart, valves or myocardium;

(iii) a 24-hour ambulatory ECG recording showing no conduction disturbance, complex or sustained rhythm disturbance or evidence of myocardial ischaemia.

(3) A tilt test carried out to a standard protocol showing no evidence of vasomotor instability may be required.

(4) Neurological review should be required.

(5) A multi-pilot limitation should be required until a period of 5 years has elapsed without recurrence. The Kuwait DGCA may determine a shorter or longer period of multi-pilot limitation according to the individual circumstances of the case.

(6) Applicants who experienced loss of consciousness without significant warning should be assessed as unfit.

(j) Blood pressure

(1) The diagnosis of hypertension should require cardiovascular review to include potential vascular risk factors.

(2) Anti-hypertensive treatment should be agreed by the Kuwait DGCA. Acceptable medication may include:

(i) non-loop diuretic agents;

(ii) ACE inhibitors;

(iii) angiotensin II/AT1 blocking agents (sartans);

(iv) slow channel calcium blocking agents;

(v) certain (generally hydrophilic) beta-blocking agents.

(3) Following initiation of medication for the control of blood pressure, applicants should be re-assessed to verify that the treatment is compatible with the safe exercise of the privileges of the licence held.

(k) Coronary artery disease

(1) Chest pain of uncertain cause should require full investigation. Applicants with angina pectoris should be assessed as unfit, whether or not it is alleviated by medication.

(2) In suspected asymptomatic coronary artery disease, exercise electrocardiography should be required. Further tests may be required, which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(3) Evidence of exercise-induced myocardial ischaemia should be disqualifying.

(4) After an ischaemic cardiac event, including revascularisation, applicants without symptoms should have reduced any vascular risk factors to an appropriate level. Medication, when used to control cardiac symptoms, is not acceptable. All applicants should be on acceptable secondary prevention treatment.

(i) A coronary angiogram obtained around the time of, or during, the ischaemic myocardial event and a complete, detailed clinical report of the ischaemic event and of any operative procedures should be available to the Kuwait DGCA:

(A) there should be no stenosis more than 50% in any major untreated vessel, in any vein or artery graft or at the site of an angioplasty/stent, except in a vessel subtending a myocardial infarction. More than two stenoses between 30% and 50% within the vascular tree should not be acceptable;

(B) the whole coronary vascular tree should be assessed as satisfactory by a cardiologist, and particular attention should be paid to multiple stenoses and/or multiple revascularisations;

(C) an untreated stenosis greater than 30% in the left main or proximal left anterior descending coronary artery should not be acceptable.

(ii) At least 6 months from the ischaemic myocardial event, including revascularisation, the following investigations should be completed (equivalent tests may be substituted):

(A) an exercise ECG showing neither evidence of myocardial ischaemia nor rhythm or conduction disturbance;

(B) an echocardiogram showing satisfactory left ventricular function with no important abnormality of wall motion (such as dyskinesia or akinesia) and a left ventricular ejection fraction of 50% or more;

(C) in cases of angioplasty/stenting, a myocardial perfusion scan or stress echocardiogram, which should show no evidence of reversible myocardial ischaemia. If there is any doubt about myocardial perfusion in other cases (infarction or bypass grafting) a perfusion scan should also be required;

(D) further investigations, such as a 24-hour ECG, may be necessary to assess the risk of any significant rhythm disturbance.

(iii) Follow-up should be annually (or more frequently, if necessary) to ensure that there is no deterioration of the cardiovascular status. It should include a review by a cardiologist, exercise ECG and cardiovascular risk assessment. Additional investigations may be required by the Kuwait DGCA.

(A) After coronary artery vein bypass grafting, a myocardial perfusion scan or equivalent test should be performed if there is any indication, and in all cases within 5 years from the procedure.

(B) In all cases, coronary angiography should be considered at any time if symptoms, signs or non-invasive tests indicate myocardial ischaemia.

(iv) Successful completion of the 6-month or subsequent review will allow a fit assessment with a multi-pilot limitation.

(l) Rhythm and conduction disturbances

(1) Any significant rhythm or conduction disturbance should require evaluation by a cardiologist and appropriate follow-up in the case of a fit assessment. Such evaluation should include:

(i) exercise ECG to the Bruce protocol or equivalent. Bruce stage 4 should be achieved and no significant abnormality of rhythm or conduction, or evidence of myocardial ischaemia should be demonstrated. Withdrawal of cardioactive medication prior to the test should normally be required;

(ii) 24-hour ambulatory ECG which should demonstrate no significant rhythm or conduction disturbance;

(iii) 2D Doppler echocardiogram which should show no significant selective chamber enlargement or significant structural or functional abnormality, and a left ventricular ejection fraction of at least 50%.

Further evaluation may include (equivalent tests may be substituted):

(iv) 24-hour ECG recording repeated as necessary;

(v) electrophysiological study;

(vi) myocardial perfusion imaging;

(vii) cardiac magnetic resonance imaging (MRI);

(viii) coronary angiogram.

(2) Applicants with frequent or complex forms of supra ventricular or ventricular ectopic complexes require full cardiological evaluation.

(3) Ablation

Applicants who have undergone ablation therapy should be assessed as unfit. A fit assessment may be considered by the Kuwait DGCA following successful catheter ablation and should require a multi-pilot limitation for at least one year, unless an electrophysiological study, undertaken at a minimum of 2 months after the ablation, demonstrates satisfactory results. For those whose long-term outcome cannot be assured by invasive or non-invasive testing, an additional period with a multi-pilot limitation and/or observation may be necessary.

(4) Supraventricular arrhythmias

Applicants with significant disturbance of supraventricular rhythm, including sinoatrial dysfunction, whether intermittent or established, should be assessed as unfit. A fit assessment may be considered by the Kuwait DGCA if cardiological evaluation is satisfactory.

(i) Atrial fibrillation/flutter

(A) For initial applicants, a fit assessment should be limited to those with a single episode of arrhythmia which is considered by the Kuwait DGCA to be unlikely to recur.

(B) For revalidation, applicants may be assessed as fit if cardiological evaluation is satisfactory and the stroke risk is sufficiently low.

(ii) Applicants with asymptomatic sinus pauses up to 2.5 seconds on resting electrocardiography may be assessed as fit if exercise electrocardiography, echocardiography and 24-hour ambulatory ECG are satisfactory.

(iii) Symptomatic sino-atrial disease should be disqualifying.

(5) Mobitz type 2 atrio-ventricular block

Applicants with Mobitz type 2 AV block should require full cardiological evaluation and may be assessed as fit in the absence of distal conducting tissue disease.

(6) Complete right bundle branch block

Applicants with complete right bundle branch block should require cardiological evaluation on first presentation and subsequently:

(i) for initial applicants under age 40, a fit assessment may be considered by the Kuwait DGCA. Initial applicants over age 40 should demonstrate a period of stability of 12 months;

(ii) for revalidation, a fit assessment may be considered if the applicant is under age 40. A multi-pilot limitation should be applied for 12 months for those over age 40.

(7) Complete left bundle branch block

A fit assessment may be considered by the Kuwait DGCA:

(i) Initial applicants should demonstrate a 3-year period of stability.

(ii) For revalidation, after a 3-year period with a multi-pilot limitation applied, a fit assessment without multi-pilot limitation may be considered.

(iii) Investigation of the coronary arteries is necessary for applicants over age 40.

(8) Ventricular pre-excitation

A fit assessment may be considered by the Kuwait DGCA:

(i) Asymptomatic initial applicants with pre-excitation may be assessed as fit if an electrophysiological study, including adequate drug-induced autonomic stimulation reveals no inducible re-entry tachycardia and the existence of multiple pathways is excluded.

(ii) Asymptomatic applicants with pre-excitation may be assessed as fit at revalidation with a multi-pilot limitation.

(9) Pacemaker

Applicants with a subendocardial pacemaker should be assessed as unfit. A fit assessment may be considered at revalidation by the Kuwait DGCA no sooner than 3 months after insertion and should require:

(i) no other disqualifying condition;

(ii) a bipolar lead system, programmed in bipolar mode without automatic mode change of the device;

(iii) that the applicant is not pacemaker dependent;

(iv) regular follow-up at least every 12 months, including a pacemaker check; and

(v) a multi-pilot limitation OML.

(10) QT prolongation

Prolongation of the QT interval on the ECG associated with symptoms should be disqualifying. Asymptomatic applicants require cardiological evaluation for a fit assessment and a multi-pilot limitation may be required.

(11) Brugada pattern on electrocardiography

Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitations as appropriate, subject to satisfactory cardiological evaluation.

***Note**: Where anticoagulation is needed for a rhythm disturbance, a fit assessment with an OML may be considered if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an OML may be considered after review by the medical assessor of the licensing authority after a stabilisation period of 3 months.*

GM1 MED.B.010 Cardiovascular system

MITRAL VALVE DISEASE

(a) Minor regurgitation should have evidence of no thickened leaflets or flail chordae and left atrial internal diameter of less than or equal to 4.0 cm.

(b) The following may indicate severe regurgitation:

(1) LV internal diameter (diastole) > 6.0 cm; or

(2) LV internal diameter (systole) > 4.1 cm; or

(3) Left atrial internal diameter > 4.5 cm.

(c) Doppler indices, such as width of jet, backwards extension and whether there is flow reversal in the pulmonary veins may be helpful in assessing severity of regurgitation.

GM2 MED.B.010 Cardiovascular system

VENTRICULAR PRE-EXCITATION

Asymptomatic applicants with pre-excitation may be assessed as fit if they meet the following criteria, which may also indicate a satisfactory electrophysiological evaluation:

(a) refractory period > 300 ms;
(b) no induced atrial fibrillation.

AMC1 MED.B.015 Respiratory system

(a) Examination

(1) Spirometry

Spirometric examination is required for initial examination. An FEV1/FVC ratio less than 70% at initial examination should require evaluation by a specialist in respiratory disease.

(2) Chest radiography

Posterior/anterior chest radiography may be required at initial, revalidation or renewal examinations when indicated on clinical or epidemiological grounds.

(b) Chronic obstructive airways disease

Applicants with chronic obstructive airways disease should be assessed as unfit. Applicants with only minor impairment of their pulmonary function may be assessed as fit.

(c) Asthma

(d) Applicants with asthma requiring medication or experiencing recurrent attacks of asthma may be assessed as fit if the asthma is considered stable with satisfactory pulmonary function tests and medication is compatible with flight safety. Systemic steroids should be assessed. As unfit Inflammatory disease

For applicants with active inflammatory disease of the respiratory system a fit assessment may be considered when the condition has resolved without sequelae and no medication is required.

(e) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Investigation should be undertaken with respect to the possibility of systemic, particularly cardiac, involvement. A fit assessment may be considered if no medication is required, and the disease is investigated and shown to be limited to hilar lymphadenopathy and inactive.

(2) Applicants with cardiac sarcoid should be assessed as unfit.

(f) Pneumothorax

(1) Applicants with a spontaneous pneumothorax should be assessed as unfit. A fit assessment may be considered if respiratory evaluation is satisfactory:

(i) 1 year following full recovery from a single spontaneous pneumothorax;

(ii) at revalidation, 6 weeks following full recovery from a single spontaneous pneumothorax, with a multi-pilot limitation; OML

(iii) following surgical intervention in the case of a recurrent pneumothorax provided there is satisfactory recovery.

(2) A recurrent spontaneous pneumothorax that has not been surgically treated is disqualifying

(3) A fit assessment following full recovery from a traumatic pneumothorax as a result of an accident or injury may be acceptable once full absorption of the pneumothorax is demonstrated.

(g) Thoracic surgery

(1) Applicants requiring major thoracic surgery should be assessed as unfit for a minimum of 3 months following operation or until such time as the effects of the operation are no longer likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(2) A fit assessment following lesser chest surgery may be considered by the Kuwait DGCA after satisfactory recovery and full respiratory evaluation.

(h) Sleep apnoea syndrome/sleep disorder

Applicants with unsatisfactorily treated sleep apnoea syndrome should be assessed as unfit.

AMC1 MED.B.020 Digestive system

(a) Oesophageal varices

Applicants with oesophageal varices should be assessed as unfit.

(b) Pancreatitis

Applicants with pancreatitis should be assessed as unfit pending assessment. A fit assessment may be considered if the cause (e.g. gallstone, other obstruction, medication) is removed.

(c) Gallstones

(3) Applicants with a single asymptomatic large gallstone discovered incidentally may be assessed as fit if not likely to cause incapacitation in flight.

(4) An applicant with asymptomatic multiple gallstones may be assessed as fit with a multi-pilot limitation.

(d) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease should be assessed as fit if the inflammatory bowel disease is in established remission and stable and that systemic steroids are not required for its control.

(e) Peptic ulceration

Applicants with peptic ulceration should be assessed as unfit pending full recovery and demonstrated healing.

(f) (f) Digestive tract and Abdominal surgery

(1) Abdominal surgery for medical conditions of the digestive tract or its adnexa, including a total or partial excision or a diversion of any of these organs or herniae should be assessed as unfit . An earlier fit assessment may be considered if recovery is complete, the applicant is asymptomatic and there is only a minimal risk of secondary complication or recurrence.

(2) Applicants who have undergone a surgical operation on the digestive tract or its adnexa, involving a total or partial excision or a diversion of any of these organs, should be assessed as unfit for a minimum period of 3 months or until such time as the effects of the operation are no longer likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(g) Liver disease

Applicants with morphological or functional liver disease, or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.

AMC1 MED.B.025 Metabolic and Endocrine systems

(a) Metabolic, nutritional or endocrine dysfunction

Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit if the condition is asymptomatic, clinically compensated and stable with or without replacement therapy, and regularly reviewed by an appropriate specialist

(b) Obesity

Applicants with a Body Mass Index 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the applicable licence(s) and a

satisfactory cardiovascular risk review has been undertaken and evaluation of the possibility of sleep apnea are satisfactory, with TML of 6 months or less duration.

(c) Addison's disease

Addison's disease is disqualifying. A fit assessment may be considered, provided that cortisone is carried and available for use whilst exercising the privileges of the licence(s). Applicants may be assessed as fit with a multi-pilot limitation OML.

(d) Gout

Applicants with acute gout should be assessed as unfit. A fit assessment may be considered once asymptomatic, after cessation of treatment or the condition is stabilised on anti-hyperuricaemic therapy.

(e) Thyroid dysfunction

Applicants with hyperthyroidism or hypothyroidism should be assessed as unfit. A fit assessment may be considered when a stable euthyroid state is attained.

(f) Abnormal glucose metabolism

Glycosuria and abnormal blood glucose levels require investigation. A fit assessment may be considered if normal glucose tolerance is demonstrated (low renal threshold) or impaired glucose tolerance without diabetic pathology is fully controlled by diet and regularly reviewed.

(g) Diabetes mellitus

Subject to good control of blood sugar with no hypoglycaemic episodes:

(1) applicants with diabetes mellitus not requiring medication may be assessed as fit;

(2) the use of antidiabetic medications that are not likely to cause hypoglycaemia may be acceptable for a fit assessment with a multi-pilot limitation OML .

AMC1 MED.B.030 Haematology

(h) Abnormal haemoglobin

Applicants with abnormal haemoglobin should be investigated.

(i) Anaemia

(1) Applicants with anaemia demonstrated by a reduced haemoglobin level or haematocrit less than 32% should be assessed as unfit and require investigation. A fit assessment may be considered in cases where the primary cause has been treated (e.g. iron or B12 deficiency) and the haemoglobin or haematocrit has stabilised at a satisfactory level.

(2) Anaemia which is unamenable to treatment is disqualifying.

(j) Polycythaemia (Erythrocytosis)

Applicants with polycythaemia (Erythrocytosis) should be assessed as unfit and require investigation. A fit assessment with a multi-pilot limitation may be considered if the condition is stable and no associated pathology is demonstrated.

(k) Haemoglobinopathy

(1) Applicants with a haemoglobinopathy should be assessed as unfit. A fit assessment may be considered where minor thalassaemia or other

haemoglobinopathy is diagnosed without a history of crises and where full functional capability is demonstrated. The haemoglobin level should be satisfactory.

(2) Applicants with sickle cell disease should be assessed as unfit.

(l) Coagulation disorders

(1) Applicants with a coagulation disorder should be assessed as unfit. A fit assessment may be considered if there is no history of significant bleeding episodes.

(2) Applicants with thrombocytopenia with a platelet count less than 75x109/L should be assessed as unfit. A fit assessment may be considered once the platelet count is above 75x109/L and stable.

(m) Haemorrhagic disorders

Applicants with a haemorrhagic disorder require investigation. A fit assessment with a multi-pilot limitation may be considered if there is no history of significant bleeding.

(n) Thrombo-embolic disorders

(1) Applicants with a thrombotic disorder require investigation. A fit assessment with a multi-pilot limitation OML may be considered when the applicant is asymptomatic and there is only minimal risk of secondary complication or recurrence of significant clotting episodes.

(2) Applicants with arterial embolus should be assessed as unfit. A fit assessment may be considered once recovery is complete, the applicant is asymptomatic, and there is only minimal risk of secondary complication or recurrence.

(3) If anticoagulation is used as treatment, refer to AMC1 MED.B.010(g).

(o) Disorders of the lymphatic system

Applicants with significant localised and generalised enlargement of the lymphatic glands and diseases of the blood should be assessed as unfit and require investigation. A fit assessment may be considered in cases of an acute infectious process which is fully recovered or Hodgkin's lymphoma or other lymphoid malignancy which has been treated and is in full remission.

(p) Leukaemia

(1) Applicants with acute leukaemia should be assessed as unfit. Once in established remission, applicants may be assessed as fit.

(2) Applicants with chronic leukaemia should be assessed as unfit. After a period of demonstrated stability a fit assessment may be considered.

(3) Applicants with a history of leukaemia should have no history of central nervous system involvement and no continuing side-effects from treatment of flight safety importance. Haemoglobin and platelet levels should be satisfactory. Regular follow-up is required.

(q) Splenomegaly

Applicants with splenomegaly should be assessed as unfit and require investigation. A fit assessment may be considered when the enlargement is minimal, stable and no associated pathology is demonstrated, or if the enlargement is minimal and associated with another acceptable condition

AMC1 MED.B.035 Genitourinary system

(a) Abnormal urinalysis

Investigation is required if there is any abnormal finding on urinalysis.

(b) Renal disease

(1) Applicants presenting with any signs of renal disease should be assessed as unfit. A fit assessment may be considered if blood pressure is satisfactory and renal function is acceptable.

(2) The requirement for dialysis should be assessed as unfit.

(c) Urinary calculi

(1) Applicants with an asymptomatic calculus or a history of renal colic require investigation.

(2) Applicants presenting with one or more urinary calculi should be assessed as unfit and require investigation.

(3) A fit assessment with a multi-pilot limitation may be considered whilst awaiting assessment or treatment.

(4) A fit assessment without multi-pilot limitation may be considered after successful treatment for a calculus.

(5) Applicants with parenchymal residual calculi, a fit assessment with a multi-pilot limitation may be considered.

(d) Renal/urological surgery

(1) Applicants who have undergone a major surgical operation on the genitourinary tract or its adnexa involving a total or partial excision or a diversion of any of its organs should be assessed as unfit for a minimum period of 3 months or until such time as the effects of the operation are no longer likely to cause incapacity in flight. After other urological surgery, a fit assessment may be considered if the applicant is completely asymptomatic and there is minimal risk of secondary complication or recurrence.

(2) An applicant with compensated nephrectomy without hypertension or uraemia may be considered for a fit assessment.

(3) Applicants who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and tolerated with only minimal immuno-suppressive therapy after at least 12 months. Applicants may be assessed as fit with a multi-pilot limitation.

(4) Applicants who have undergone total cystectomy may be considered for a fit assessment if there is satisfactory urinary function, no infection and no recurrence of primary pathology. Applicants may be assessed as fit with a multi-pilot limitation.

AMC1 MED.B.040 Infectious disease

(a) Infectious disease - General

In cases of infectious disease, consideration should be given to a history of, or clinical signs indicating, underlying impairment of the immune system.

(b) Tuberculosis

Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy. Applicants with quiescent or healed lesions may be assessed as fit.

(c) Syphilis

Acute syphilis should be assessed as unfit. A fit assessment may be considered in the case of those fully treated and recovered from the primary and secondary stages.

(d) HIV infection

Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)

(e) Infectious hepatitis

Infectious hepatitis is disqualifying. A fit assessment may be considered after full recovery, Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.

AMC1 MED.B.045 Obstetrics and gynaecology

(a) Gynaecological surgery

An applicant who has undergone a major gynaecological operation should be assessed as unfit for a period of 3 months or until such time as the effects of the operation are not likely to interfere with the safe exercise of the privileges of the licence(s) if the holder is completely asymptomatic and there is only a minimal risk of secondary complication or recurrence.

(b) Severe menstrual disturbances

An applicant with a history of severe menstrual disturbances unamenable to treatment should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic.

(c) Pregnancy

(1) A pregnant licence holder may be assessed as fit with a multi-pilot limitation during the first 26 weeks of gestation, following review of the obstetric evaluation by the AeMC or AME who should inform Kuwait DGCA.

(2) The AeMC or AME should provide written advice to the applicant and the supervising physician regarding potentially significant complications of flying during pregnancy.

AMC1 MED.B.050 Musculoskeletal system

(a) An applicant with any significant sequela from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery requires full evaluation prior to a fit assessment.

(b) In cases of limb deficiency, a fit assessment may be considered following a satisfactory medical flight test or simulator testing.

(c) An applicant with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission and the applicant is taking no disqualifying medication and has satisfactorily completed a medical flight or simulator flight test. Appropriate limitation to specified aircraft type(s) may be required.

(d) Applicants with abnormal musculoskeletal physique, including obesity, or muscular weakness may require medical flight or flight simulator testing. Particular attention should be paid to emergency procedures and evacuation. Appropriate limitation or to specified aircraft type(s) may be required.

AMC1 MED.B.055 (Mental Health)

(A) Mental health assessment as part of the initial class 1 aero-medical examination :

(1) A comprehensive mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.

(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.

(3) The mental health assessment should include assessment and documentation of:

(i) general attitudes to mental health, including understanding possible indications of reduced mental health in themselves and others;

(ii) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;

(iii) childhood behavioural problems;

(iv) interpersonal and relationship issues;

(v) current work and life stressors; and

(vi) overt personality disorders.

(4) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(B) Mental health assessment as part of revalidation or renewal class 1 medical examination

(1) The assessment should include review and documentation of:

(i) current work and life stressors;

(ii) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;

(iii) any difficulties with operational crew resource management (CRM);

(iv) any difficulties with employer and/or other colleagues and managers; and

(v) interpersonal and relationship issues, including difficulties with relatives, friends, and work colleagues.

(2) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(3) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).

c) Assessment of holders of a class 1 medical certificate referenced in MED.B.055(d)

Assessment of holders of a class 1 medical certificate referenced in MED.B.055(d) may require psychiatric and psychological evaluation as determined by the medical assessor of the DGCA. A SIC limitation should be imposed in case of a fit assessment. Follow-up and removal of SIC limitation, as necessary, should be determined by the medical assessor of the DGCA.

(d) Psychoactive substance testing

(1) Drug tests should screen for opioids, cannabinoids, amphetamines, cocaine, hallucinogens and sedative hypnotics. Following a risk assessment performed by a competent authority on the target population, screening tests may include additional drugs.

(2) For renewal/revalidation, random psychoactive substance screening test may be performed based on the risk assessment by a competent authority on the target population. If random psychoactive substance screening test is considered, it should be performed and reported in accordance with the procedures developed by a competent authority.

(3) In the case of a positive psychoactive substance screening result, confirmation should be required in accordance with national standards and procedures for psychoactive substance testing.

(4) In case of a positive confirmation test, a psychiatric evaluation should be undertaken before a fit assessment may be considered by the medical assessor of the DGCA.

(e) Assessment and referral decisions

(1) Psychotic disorder

A history, or the occurrence, of a functional psychotic disorder should be assessed as unfit . A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and will not recur.

(2) Organic mental disorder

Applicant with an organic mental disorder should be assessed as unfit. Once the cause has been treated, an applicant may be assessed as fit following satisfactory psychiatric review.

(3) Psychotropic substances or medication:

Use or abuse of psychotropic substances or medication that is likely to affect flight safety is disqualifying.

Applicants who use psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with an OML may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed

(4) Schizophrenia, schizotypal or delusional disorder

Applicants with an established schizophrenia, schizotypal or delusional disorder should only be considered for a fit assessment if the Kuwait DGCA concludes that the original diagnosis was inappropriate or inaccurate or, in the case of a single episode of delirium, provided that the applicant has suffered no permanent impairment.

(5) Mood disorder

An established mood disorder should be assessed as unfit. After full recovery and after full consideration of an individual case a fit assessment may be considered, depending on the characteristics and gravity of the mood disorder. If a stable maintenance psychotropic medication is confirmed, a fit assessment should require a multi-pilot limitation.

(6) Neurotic, stress-related or somatoform disorder

Where there is suspicion or established evidence that an applicant has a neurotic, stress- related or somatoform disorder, the applicant should be referred for psychiatric opinion and advice.

(7) Personality or behavioural disorder

Where there is suspicion or established evidence that an applicant has a personality or behavioural disorder, the applicant should be referred for psychiatric opinion and advice.

(8) Disorders due to alcohol or other substance use

i. Applicant with mental or behavioural disorders due to alcohol or other substance use, with or without dependency, should be assessed as unfit.

ii. A fit assessment may be considered after a period of two years documented sobriety or freedom from substance use. At revalidation or renewal a fit assessment may be considered earlier with a multi-pilot limitation. Depending on the individual case, treatment and review may include:

- in-patient treatment of some weeks of inclusion into support programme with regular reports followed by:
  - review by a psychiatric specialist; and
  - ongoing review including blood testing and peer reports, which may be required indefinitely.

(9) Deliberate self-harm

Applicants who have carried out a single self-destructive action or repeated acts of deliberate self-harm should be assessed as unfit. A fit assessment may be considered after full consideration of an individual case and may require psychiatric or psychological review. Neuropsychological assessment may also be required.

(10) Assessment

The assessment should take into consideration if the indication for the treatment, side effects and addiction risks of such treatment and the characteristics of the psychiatric disorder are compatible with flight safety.

(j) Specialist opinion and advice

(1) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC or medical assessor of the DGCA as appropriate, detailing their opinion and recommendation.

(2) Psychiatric evaluations should be conducted by a qualified psychiatrist having adequate knowledge and experience in aviation medicine.

(3) The psychological opinion and advice should be based on a clinical psychological assessment conducted by a suitably qualified and accredited clinical psychologist with expertise and experience in aviation psychology.

(4) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and clinical interview.

AMC2 MED.B.055 Mental health

(a) Mental health assessment as part of class 2 aero-medical examination

(1) A mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.

(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.

(3) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(4) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).

(b) Assessment of holders of a class 2medical certificate referenced in MED.B.055(d)

Assessment of holders of a class 2 medical certificate referenced in MED.B.055(d) may require psychiatric and psychological evaluation as determined by the AME, AeMC or medical assessor of the licensing authority. Follow-up, as necessary, should be determined in consultation with the medical assessor of the licensing authority.

(c) Assessment and referral decisions

(1) Psychotic disorder

Applicants with a history, or the occurrence, of a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and the risk of recurrence is minimal.

(2) Organic mental disorder

Applicants with an organic mental disorder should be assessed as unfit. Once the cause has been treated, an applicant may be assessed as fit following satisfactory psychiatric evaluation.

(3) Schizophrenia, schizotypal or delusional disorder

Applicants with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder may only be considered for a fit assessment in consultation with the medical assessor of the licensing authority if the original diagnosis was inappropriate or inaccurate as confirmed by psychiatric evaluation, or, in the case of a single episode of delirium of which the cause was clear, provided that the applicant has suffered no permanent mental impairment.

(4) Mood disorder

Applicants with an established mood disorder should be assessed as unfit. After full recovery and after full consideration of the individual case, a fit assessment may be considered, depending on the characteristics and severity of the mood disorder.

(5) Neurotic, stress-related or somatoform disorder

Where there are signs or is established evidence that an applicant may have a neurotic, stress-related or somatoform disorder, the applicant should be referred for psychiatric opinion and advice.

(6) Personality or behavioural disorders

Where there are signs or is established evidence that an applicant may have a personality or behavioural disorder, the applicant should be referred for psychiatric opinion and advice.

(7) Psychoactive medication

Applicants who use psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with an OSL or OPL may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed.

(8) Disorders due to alcohol or other psychoactive substance(s) use or misuse

(i) Applicants with mental or behavioural disorders due to alcohol or other psychoactive substance(s) use or misuse, with or without dependency, should be assessed as unfit.

(ii) Drug and alcohol tests

(A) In the case of a positive drug or alcohol result, confirmation should be required in accordance with national procedures for drugs and alcohol testing.

(B) In case of a positive confirmation test, a psychiatric evaluation should be undertaken before a fit assessment may be considered.

(iii) A fit assessment may be considered after a period of two years of documented sobriety or freedom from psychoactive substance use or misuse. At revalidation or renewal, a fit assessment may be considered earlier with an OSL or OPL. Depending on the individual case, treatment and evaluation may include in-patient treatment of some weeks and inclusion into a support programme followed by ongoing checks, including drug and alcohol testing and reports resulting from the support programme, which may be required indefinitely.

(9) Deliberate self-harm

Applicants who have carried out a single self-destructive action or repeated acts of deliberate self-harm or suicide attempt should be assessed as unfit. A fit assessment may be considered after full consideration of an individual case and may require psychiatric or psychological evaluation. Neuropsychological evaluation may also be required.

(e) Specialist opinion and advice

(1) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC or medical assessor of the licensing authority as appropriate, detailing their opinion and recommendation.

(2) Psychiatric evaluations should be conducted by a qualified psychiatrist having adequate knowledge and experience in aviation medicine.

(3) The psychological opinion and advice should be based on a clinical psychological assessment conducted by a suitably qualified and accredited clinical psychologist with expertise and experience in aviation psychology.

(4) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and clinical interview.

GM1 MED.B.055 Mental health

(a) Symptoms of concern may include but are not limited to:

(1) use of alcohol or other psychoactive substances;

(2) loss of interest/energy;

(3) eating and weight changes;

(4) sleeping problems;

(5) low mood and, if present, any suicidal thoughts;

(6) family history of psychiatric disorders, particularly suicide;

(7) anger, agitation or high mood; and

(8) depersonalisation or loss of control.

(b) The following aspects should be taken into consideration when conducting the mental health examination:

(1) Appearance;

(2) Attitude;

(3) Behaviour;

(4) Mood;

(5) Speech;

(6) Thoughts process and content;

(7) Perception;

(8) Cognition;

(9) Insight; and

(10) Judgement.

GM2 MED.B.055 Mental health

(a) Drugs and alcohol screening tests used should:

(1) provide information regarding medium-term consumption;

(2) be accepted on national level by the competent authority based on the availability and suitability for the scope mentioned in point(a)(1) above.

(b) Statistical data of the screening campaign mentioned in AMC1 MED.B.055(d)(1) should be made available to the Agency on a yearly basis.

AMC1 MED.B.060 Psychology

(a) Where there is suspicion or established evidence that an applicant has a psychological disorder, the applicant should be referred for psychological opinion and advice.

(b) Established evidence should be verifiable information from an identifiable source which evokes doubts concerning the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or

proficiency checks, delinquency or knowledge relevant to the safe exercise of the privileges of the applicable licence.

(c) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and psychological interview.

(d) The psychologist should submit a written report to the AME, AeMC or the Kuwait DGCA as appropriate, detailing his/her opinion and recommendation.

AMC1 MED.B.065 Neurology

(a) Epilepsy

(1) A diagnosis of epilepsy should be assessed as unfit, unless there is unequivocal evidence of a syndrome of benign childhood epilepsy associated with a very low risk of recurrence, and unless the applicant has been free of recurrence and off treatment for more than 10 years. One or more convulsive episodes after the age of 5 are disqualifying. In the case of an acute symptomatic seizure, which is considered to have a very low risk of recurrence, a fit assessment may be considered after neurological review.

(2) An applicant may be assessed as fit by the Kuwait DGCA with a multi-pilot limitation if:

(i) there is a history of a single afebrile epileptiform seizure;

(ii) there has been no recurrence after at least 10 years off treatment;

(iii) there is no evidence of continuing predisposition to epilepsy.

(b) Conditions with a high propensity for cerebral dysfunction

An applicant with a condition with a high propensity for cerebral dysfunction should be assessed as unfit. A fit assessment may be considered after full evaluation.

(c) Clinical EEG abnormalities

(1) Electroencephalography is required when indicated by the applicant's history or on clinical grounds.

(2) Epileptiform paroxysmal EEG abnormalities and focal slow waves should be disqualifying.

(d) Neurological disease

Any stationary or progressive disease of the nervous system which has caused or is likely to cause a significant disability is disqualifying. However, in case of minor functional losses associated with stationary disease, a fit assessment may be considered after full evaluation.

(e) Episode of disturbance of consciousness

In the case of a single episode of disturbance of consciousness, which can be satisfactorily explained, a fit assessment may be considered, but a recurrence should should be assessed as unfit.

(f) Head injury

An applicant with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury should be reviewed by a consultant neurologist. A fit assessment may be considered if there has been a full recovery and the risk of epilepsy is sufficiently low.

(g) Spinal or peripheral nerve injury, myopathies

An applicant with a history or diagnosis of spinal or peripheral nerve injury or myopathy should be assessed as unfit. A fit assessment may be considered if neurological review and musculoskeletal assessments are satisfactory.

(h) Vascular deficiencies

Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC1 MED.B.050 are satisfied. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.

(i) Migraine

Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, therapy. Appropriate limitation(s) may apply.

AMC1 MED.B.070 Visual system

(a) Eye examination

(1) At each aero-medical revalidation examination, an assessment of the visual fitness should be undertaken and the eyes should be examined with regard to possible pathology.

(2) All abnormal and doubtful cases should be referred to an ophthalmologist. Conditions which indicate ophthalmological examination include, but are not limited to, a substantial decrease in the uncorrected visual acuity, any decrease in best corrected visual acuity and/or the occurrence of eye disease, eye injury, or eye surgery.

(3) Where specialist ophthalmological examinations are required for any significant reason, this should be imposed as a limitation on the medical certificate.

(b) Comprehensive eye examination

A comprehensive eye examination by an eye specialist is required at the initial examination. All abnormal and doubtful cases should be referred to an ophthalmologist. The examination should include:

(1) history;

(2) visual acuities - near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(3) examination of the external eye, anatomy, media (slit lamp) and fundoscopy;

(4) ocular motility;

(5) binocular vision;

(6) visual fields;

~~(1) colour vision;~~

(7) tonometry on clinical indication; and

(8) objective refraction: hyperopic initial applicants with a hyperopia of more than +2 dioptres and under the age of 25 should undergo objective refraction in cycloplegia;.

(9) assessment of mesopic contrast sensitivity; and

(10) colour vision;

(c) Routine eye examination

A routine eye examination may be performed by an AME and should include:

(1) history;

(2) visual acuities - near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(3) examination of the external eye, anatomy, media and fundoscopy (when indicated) ;

(4) further examination on clinical indication.

(d) Refractive error and anisometropia

(1) At initial examination an applicant may be assessed as fit with:

(i) hypermetropia not exceeding +5.0 dioptres;

(ii) myopia not exceeding –6.0 dioptres;

(iii) astigmatism not exceeding 2.0 dioptres;

(iv) anisometropia not exceeding 2.0 dioptres

provided that optimal correction has been considered and no significant pathology is demonstrated.

(2) Initial applicants who do not meet the requirements in (1) (ii), (iii) and (iv) above should be referred to Kuwait DGCA. A fit assessment may be considered following review by an ophthalmologist.

(i) hypermetropia exceeds +5.0 dioptres;

(ii) anisometropia exceeds 3.0 dioptres

(3) At revalidation an applicant may be assessed as fit with:

(i) (the refractive error is between –3.0 and –6.0 dioptres or +3 and +5 dioptres;

(ii) astigmatism or anisometropia is between 2.0 and 3.0 dioptres.(4) An evaluation by an eye specialist should be undertaken 2-yearly if:

(ii) the refractive error is greater than –6.0 dioptres or +5.0 dioptres;

(ii) astigmatism or anisometropia exceeds 3.0 dioptres. provided that optimal correction has been considered and no significant pathology is demonstrated.

(4) If anisometropia exceeds 3.0 dioptres, contact lenses should be worn.

(5) If the refractive error is +3.0 to +5.0 or –3.0 to –6.0 dioptres, there is astigmatism or anisometropia of more than 2 dioptres but less than 3 dioptres, a review should be undertaken 5 yearly by an eye specialist.

(6) If the refractive error is greater than –6.0 dioptres, there is more than 3.0 dioptres of astigmatism or anisometropia exceeds 3.0 dioptres, a review should be undertaken 2 yearly by an eye specialist.

(7) In cases (5) and (6) above, the applicant should supply the eye specialist's report to the AME. The report should be forwarded to the Kuwait DGCA as part of the medical examination report. All abnormal and doubtful cases should be referred to an ophthalmologist.

(e) Uncorrected visual acuity

No limits apply to uncorrected visual acuity.

(f) Substandard vision

(1) Applicants with reduced central vision in one eye may be assessed as fit if the binocular visual field is normal and the underlying pathology is acceptable according to ophthalmological assessment. A satisfactory medical flight test and a multi-pilot limitation are required.

(2) An applicant with acquired substandard vision in one eye may be assessed as fit with a multi-pilot limitation if:

(i) the better eye achieves distant visual acuity of 6/6 (1.0), corrected or uncorrected;

(ii) the better eye achieves intermediate visual acuity of N14 and N5 for near;

(iii) in the case of acute loss of vision in one eye, a period of adaptation time has passed from the known point of visual loss, during which the applicant should be assessed as unfit;

(iv) there is no significant ocular pathology; and

(v) a medical flight test is satisfactory.

(3) An applicant with a visual field defect may be assessed as fit if the binocular visual field is normal and the underlying pathology is acceptable to the Kuwait DGCA.

(g) Keratoconus

Applicants with keratoconus may be assessed as fit if the visual requirements are met with the use of corrective lenses and periodic review is undertaken by an ophthalmologist.

(h) Heterophoria

Applicants with heterophoria (imbalance of the ocular muscles) exceeding:

(1) at 6 metres:

2.0 prism dioptres in hyperphoria;

10.0 prism dioptres in esophoria;

8.0 prism dioptres in exophoria; and

(2) at 33 centimetres:

1.0 prism dioptre in hyperphoria;

8.0 prism dioptres in esophoria;

12.0 prism dioptres in exophoria;

should be assessed as unfit. The applicant should be reviewed by an ophthalmologist and if the fusional reserves are sufficient to prevent asthenopia and diplopia a fit assessment may be considered.

(i) Eye surgery

The assessment after eye surgery should include an ophthalmological examination.

(1) After refractive surgery, a fit assessment may be considered, provided that:

(i) pre-operative refraction was not greater than +5 dioptres;

(ii) post-operative stability of refraction has been achieved (less than 0.75 dioptres variation diurnally);

(iii) examination of the eye shows no post-operative complications;

(iv) glare sensitivity is within normal standards;

(v) mesopic contrast sensitivity is not impaired;

(vi) review is undertaken by an eye specialist.

(11) Cataract or intraocular lens surgery entails unfitness. A fit assessment may be considered after 3 months once recovery is complete and the visual requirements are met with or without correction. Intraocular lenses should be monofocal and should not impair colour vision and night vision .

(12) Retinal surgery entails unfitness. A fit assessment may be considered 6 months after successful surgery. A fit assessment may be acceptable earlier after retinal laser therapy. Follow-up may be required.

(13) Glaucoma surgery entails unfitness. A fit assessment may be considered 6 months after successful surgery. Follow-up may be required.

(j) Correcting lenses

Correcting lenses should permit the licence holder to meet the visual requirements at all distances.

AMC1 MED B.075 Colour vision

(a) At revalidation, colour vision should be tested on clinical indication.

(a) The Ishihara test (24 plate version) is considered passed if the first 15 plates, presented in a random order, are identified without error.

(b) Those failing the Ishihara test should be examined either by:

(1) anomaloscopy (Nagel or equivalent). This test is considered passed if the colour match is trichromatic and the matching range is 4 scale units or less; or by

(2) lantern testing with a Spectrolux, Beynes or Holmes-Wright lantern. This test is considered passed if the applicant passes without error a test with accepted lanterns

(3) Colour Assessment and Diagnosis (CAD) test.

This test is considered passed if the threshold is less than 6 standard normal (SN) units for deutan deficiency, or less than 12 SN units for protan deficiency. A threshold greater than 2 SN units for tritan deficiency indicates an acquired cause which should be investigated.

AMC1 MED.B.080 Otorhino-laryngology

(a) Hearing

(1) The applicant should understand correctly conversational speech when tested with each ear at a distance of 2 metres from and with the applicant's back turned towards the AME.

(2) The pure tone audiogram should cover the 500 Hz, 1000 Hz, 2000 Hz and 3000 Hz frequency thresholds.

(3) An applicant with hypoacusis should be referred to the Kuwait DGCA. A fit assessment may be considered if a speech discrimination test or functional flight deck hearing test demonstrates satisfactory hearing ability. A vestibular function test may be appropriate.

(4) If the hearing requirements can only be met with the use of hearing aids, the hearing aids should provide optimal hearing function, be well tolerated and suitable for aviation purposes.

(c) Comprehensive otorhinolaryngological examination

A comprehensive otorhino-laryngological examination should include:

(1) history;

(2) clinical examination including otoscopy, rhinoscopy, and examination of the mouth and throat;

(3) tympanometry or equivalent;

(4) clinical assessment of the vestibular system.

(d) Ear conditions

(1) An applicant with an active pathological process, acute or chronic, of the internal or middle ear should be assessed as unfit. A fit assessment may be considered once the condition has stabilised or there has been a full recovery.

(2) An applicant with an unhealed perforation or dysfunction of the tympanic membranes should be assessed as unfit. An applicant with a single dry perforation of non-infectious origin and which does not interfere with the normal function of the ear may be considered for a fit assessment.

(e) Vestibular disturbance

An applicant with disturbance of vestibular function should be assessed as unfit. A fit assessment may be considered after full recovery. The presence of spontaneous or positional nystagmus requires complete vestibular evaluation by an ENT specialist. Significant abnormal caloric or rotational vestibular responses are disqualifying. Abnormal vestibular responses should be assessed in their clinical context.

(f) Sinus dysfunction

An applicant with any dysfunction of the sinuses should be assessed as unfit until there has been full recovery.

(g) Oral/upper respiratory tract infections

A significant, acute or chronic infection of the oral cavity or upper respiratory tract should be assessed as unfit . A fit assessment may be considered after full recovery.

(h) Speech disorder

A significant disorder of speech or voice is disqualifying.

(i) Air passage restrictions

Applicants with significant restriction of the nasal air passage on either side, or significant malformation of the oral cavity or upper respiratory tract may be assessed as fit if ENT evaluation is satisfactory.

(j) Eustachian tube(s) dysfunction

Applicants with permanent dysfunction of the Eustachian tube(s) may be assessed as fit if ENT evaluation is satisfactory.

(k) Sequelae of surgery of the internal or middle ear

Applicants with sequelae of surgery of the internal or middle ear should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

GM1 MED.B.080 Otorhinolaryngology (ENT)

PURE TONE AUDIOGRAM

The pure tone audiogram may also cover the 4 000 Hz frequency for early detection of decrease in hearing.

AMC1 MED.B.085 Dermatology

(a) Referral to the Kuwait DGCA should be made if doubt exists about the fitness of an applicant with eczema (exogenous and endogenous), severe psoriasis, bacterial infections, drug induced, or bullous eruptions or urticaria.

(b) Systemic effects of radiant or pharmacological treatment for a dermatological condition should be considered before a fit assessment can be considered.

(c) In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be considered.

AMC1 MED.B.090 Oncology

(a) Applicants who underwent treatment for malignant disease may be assessed as fit by the Kuwait DGCA if:

(1) there is no evidence of residual malignant disease after treatment;

(2) time appropriate to the type of tumour has elapsed since the end of treatment;

(3) the risk of inflight incapacitation from a recurrence or metastasis is sufficiently low;

(4) there is no evidence of short or long-term sequelae from treatment. Special attention should be paid to applicants who have received anthracycline chemotherapy;

(5) satisfactory oncology follow-up reports are provided to the Kuwait DGCA.

(b) A multi-pilot limitation should be applied as appropriate.

(c) Applicants with pre-malignant conditions of the skin may be assessed as fit if treated or excised as necessary and there is regular follow-up.

(d) Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.

2. Class Two

AMC2 MED.B.010 Cardiovascular system

(a) Examination

Exercise electrocardiography

An exercise ECG when required as part of a cardiovascular assessment should be symptom-limited and completed to a minimum of Bruce Stage IV or equivalent.

(b) General

(6) Cardiovascular risk factor assessment

An accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) requires cardiovascular evaluation.

(7) Cardiovascular assessment

Reporting of resting and exercise electrocardiograms should be by the AME or an accredited specialist.

(c) Peripheral arterial disease

A fit assessment may be considered for an applicant with peripheral arterial disease, or after surgery for peripheral arterial disease, provided there is no significant functional impairment, any vascular risk factors have been reduced to an appropriate level, the applicant is receiving acceptable secondary prevention treatment, and there is no evidence of myocardial ischaemia.

(d) Aortic aneurysm

(1) Applicants with an aneurysm of the thoracic or supra renal abdominal aorta of less than 5 cm may be assessed as fit with ORL or OSL, subject to satisfactory cardiological evaluation and regular follow-up.

(2) Applicants may be assessed as fit after surgery for a thoracic or abdominal or supra renal aortic aneurysm subject to satisfactory cardiological evaluation to exclude the presence of coronary artery disease.

(3) Applicants with an aneurysm of the infra-renal abdominal aorta of less than 5 cm in diameter may be assessed as fit, subject to satisfactory cardiological evaluation. Regular cardiological evaluations should be carried out.

(e) Cardiac valvular abnormalities

(1) Applicants with previously unrecognised cardiac murmurs require further cardiological evaluation.

(2) Applicants with minor cardiac valvular abnormalities may be assessed as fit.

(3) Aortic valve disease

(i) Applicants with a bicuspid aortic valve may be assessed as fit if no other cardiac or aortic abnormality is demonstrated. Follow-up with echocardiography, as necessary, should be determined in consultation with the DGCA medical assessor.

(ii) Applicants with aortic stenosis may be assessed as fit provided the left ventricular function is intact and the mean pressure gradient is less than 20 mmHg. Applicants with an aortic valve orifice of more than 1 cm^2 and a mean pressure gradient above 20 mmHg, but not greater than 50 mmHg, may be assessed as fit with an ORL or OSL. Follow-up with 2D Doppler echocardiography, as necessary, should be determined in consultation with DGCA medical assessor in all cases. Alternative measurement techniques with equivalent ranges may be used. Regular cardiological evaluation should be considered. Applicants with a history of systemic embolism or significant dilatation of the thoracic aorta should be assessed as unfit.

(iii) Applicants with trivial aortic regurgitation may be assessed as fit. Applicants with a greater degree of aortic regurgitation may be assessed as fit with an OSL. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Follow-up, as necessary, should be determined in consultation with the medical assessor of the licensing authority.

(4) Mitral valve disease

(i) Asymptomatic applicants with an isolated mid-systolic click due to mitral leaflet prolapse may be assessed as fit.

(ii) Applicants with rheumatic mitral stenosis should be assessed as unfit.

(iii) Applicants with minor regurgitation may be assessed as fit. Periodic cardiological review should be determined in consultation with the medical assessor of the licensing authority.

(iv) Applicants with moderate mitral regurgitation may be considered as fit with an ORL or OSL if the 2D Doppler echocardiogram demonstrates satisfactory left ventricular dimensions and satisfactory myocardial function is confirmed by exercise electrocardiography. Periodic cardiological review should be determined in consultation with DGCA medical assessor.

(v) Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter or evidence of systolic impairment should be assessed as unfit.

(f) Valvular surgery

(1) Applicants who have undergone cardiac valve replacement or repair may be assessed as fit if post-operative cardiac function and investigations are satisfactory and no anticoagulants are needed.

(2) Where anticoagulation is needed after valvular surgery, a fit assessment with an OSL or OPL limitation may be considered after cardiological review. The review should show that the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.

(g) Thromboembolic disorders

Arterial or venous thrombosis or pulmonary embolism are disqualifying whilst anticoagulation is being used as treatment. After 6 months of stable anticoagulation as prophylaxis, a fit assessment with an OSL or OPL limitation may be considered after review in consultation with the Kuwait DGCA. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. Pulmonary embolus should require full evaluation.

(h) Other cardiac disorders

(1) Applicants with a primary or secondary abnormality of the pericardium, myocardium or endocardium may be assessed as unfit pending satisfactory cardiological evaluation.

(2) Applicants with a congenital abnormality of the heart, including those who have undergone surgical correction, may be assessed as fit subject to satisfactory cardiological assessment. Cardiological follow-up may be necessary and should be determined in consultation with the Kuwait DGCA.

(i) Syncope

Applicants with a history of recurrent vasovagal syncope may be assessed as unfit.A fit assessment may be consider after a 6-month period without recurrence, provided that cardiological evaluation is satisfactory. Neurological review may be indicated.

A single episode of vasovagal syncope which can be explained and is compatible with flight safety, a fit assessment may be considered

(j) Blood pressure

(1) When the blood pressure at examination consistently exceeds 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment, the applicant should be assessed as unfit.

(2) The diagnosis of hypertension requires review of other potential vascular risk factors.

(3) Applicants with symptomatic hypotension should be assessed as unfit.

(4) Anti-hypertensive treatment should be compatible with flight safety.

(5) Following initiation of medication for the control of blood pressure, applicants should be re-assessed to verify that the treatment is compatible with the safe exercise of the privileges of the licence held.

(k) Coronary artery disease

(1) Chest pain of uncertain cause requires full investigation. evidence of exercise-induced myocardial ischaemia should be assessed as unfit.

(2) In suspected asymptomatic coronary artery disease cardiological evaluation should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(3) After an ischaemic cardiac event, or revascularisation, applicants without symptoms should have reduced any vascular risk factors to an appropriate level. Medication, when used to control angina pectoris, is not acceptable. All applicants should be on acceptable secondary prevention treatment.

(4) A coronary angiogram obtained around the time of, or during, the ischaemic myocardial event and a complete, detailed clinical report of the ischaemic event and of any operative procedures should be available to the AME.

(5) There should be no stenosis more than 50% in any major untreated vessel, in any vein or artery graft or at the site of an angioplasty/stent, except in a vessel subtending a myocardial infarction. More than two stenoses between 30% and 50% within the vascular tree should not be acceptable.

(6) The whole coronary vascular tree should be assessed as satisfactory and particular attention should be paid to multiple stenoses and/or multiple revascularisations.

(7) An untreated stenosis greater than 30% in the left main or proximal left anterior descending coronary artery should not be acceptable.

(8) (At least 6 months from the ischaemic myocardial event, including revascularisation, the following investigations should be completed (equivalent tests may be substituted):

(9) an exercise ECG showing neither evidence of myocardial ischaemia nor rhythm disturbance;

(10) an echocardiogram showing satisfactory left ventricular function with no important abnormality of wall motion and a satisfactory left ventricular ejection fraction of 50 % or more;

(11) in cases of angioplasty/stenting, a myocardial perfusion scan or stress echocardiogram which should show no evidence of reversible myocardial ischaemia. If there is doubt about revascularisation in myocardial infarction or bypass grafting, a perfusion scan should also be required;

(12) further investigations, such as a 24-hour ECG, may be necessary to assess the risk of any significant rhythm disturbance.

(13) Periodic follow-up should include cardiological review.

(14) After coronary artery bypass grafting, a myocardial perfusion scan (or satisfactory equivalent t est) should be performed if there is any indication, and in all cases within five years from the procedure for a fit assessment without an OSL,OPL,ORL limitation.

(15) In all cases, coronary angiography should be considered at any time if symptoms, signs or non-invasive tests indicate myocardial ischaemia.

(16) Successful completion of the six month or subsequent review will allow a fit assessment. Applicants may be assessed as fit with an ORL or OSL limitation having successfully completed only an exercise ECG.

(17) Angina pectoris should be assessed as unfit , whether or not it is abolished by medication.

(l) Rhythm and conduction disturbances

Any significant rhythm or conduction disturbance should require cardiological evaluation and an appropriate follow-up before a fit assessment may be considered. An OSL or OPL limitation should be considered as appropriate.

(1) Ablation

A fit assessment may be considered following successful catheter ablation subject to satisfactory cardiological review undertaken at a minimum of 2 months after the ablation.

(2) Supraventricular arrhythmias

(i) Applicants with significant disturbance of supraventricular rhythm, including sinoatrial dysfunction, whether intermittent or established, may be assessed as fit if cardiological evaluation is satisfactory.

(ii) Applicants with atrial fibrillation/flutter may be assessed as fit if cardiological evaluation is satisfactory. An Automatic implantable defibrillating system is unfit.

(iii) Applicants with asymptomatic sinus pauses up to 2.5 seconds on resting electrocardiography may be assessed as fit if cardiological evaluation is satisfactory.

(3) Heart block

(i) Applicants with first degree and Mobitz type 1 AV block may be assessed as fit.

(ii) Applicants with Mobitz type 2 AV block may be assessed as fit in the absence of distal conducting tissue disease.

(4) Complete right bundle branch block

Applicants with complete right bundle branch block may be assessed as fit with appropriate limitations, such as an ORL subject to satisfactory cardiological evaluation.

(5) Complete left bundle branch block

Applicants with complete left bundle branch block may be assessed as fit with appropriate limitations, such as an ORL subject to satisfactory cardiological assessment.

(6) Ventricular pre-excitation

Asymptomatic applicants with ventricular pre-excitation may be assessed as fit subject to satisfactory cardiological evaluation and an electrophysiological study is conducted and the results are satisfactory .

(7) Pacemaker

Applicants with a subendocardial pacemaker may be assessed as unfit. A fit assessment may be considered no sooner than 3 months after insertion provided:

(i) there is no other disqualifying condition;

(ii) a bipolar lead system is used, programmed in bipolar mode without automatic mode change of the device;

(iii) the applicant is not pacemaker dependent; and

(iv) the applicant has a regular follow-up, including a pacemaker check.

(v) ventricular ant-tachycardia pacemaker should be assessed as unfit.

(8) QT prolongation

Applicants with asymptomatic QT prolongation may be assessed as fit with an ORL or OSL subject to satisfactory cardiological evaluation.

(9) Brugada pattern on electrocardiography

Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitation(s) as appropriate, subject to satisfactory cardiological evaluation.

AMC2 MED.B.015 Respiratory system

(a) Chest radiography

Posterior/anterior chest radiography may be required if indicated on clinical grounds.

(b) Chronic obstructive airways disease

Applicants with only minor impairment of pulmonary function may be assessed as fit.

(c) Asthma

Applicants with asthma may be assessed as fit if the asthma is considered stable with satisfactory spirometric pulmonary function tests and medication is compatible with flight safety. Systemic steroids should be disqualifying.

(d) Inflammatory disease

Applicants with active inflammatory disease of the respiratory system should be assessed as unfit pending resolution of the condition.

(e) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Investigation should be undertaken with respect to the possibility of systemic involvement. A fit assessment may be considered once the disease is inactive.

(2) Applicants with cardiac sarcoid should be assessed as unfit.

(f) Pneumothorax

(1) Applicants with spontaneous pneumothorax should be assessed as unfit. A fit assessment may be considered if respiratory evaluation is satisfactory six weeks following full recovery from a single spontaneous pneumothorax or following recovery from surgical intervention in the case of treatment for a recurrent pneumothorax.

(2) A fit assessment following full recovery from a traumatic pneumothorax as a result of an accident or injury may be acceptable once full absorption of the pneumothorax is demonstrated.

(g) Thoracic surgery

Applicants requiring major thoracic surgery should be assessed as unfit until recovery and the effects of the operation are no longer likely to interfere with the safe exercise of the privileges of the applicable licence(s). Pneumonectomy should be assessed as unfit.

(h) Sleep apnoea syndrome

Applicants with unsatisfactorily treated sleep apnoea syndrome should be assessed as unfit.

AMC2 MED.B.020 Digestive system

(a) Oesophageal varices

Applicants with oesophageal varices should be assessed as unfit.

(b) Pancreatitis

Applicants with pancreatitis should be assessed as unfit pending satisfactory recovery.

(c) Gallstones

(1) Applicants with a single asymptomatic large gallstone or asymptomatic multiple gallstones may be assessed as fit.

(2) Applicants with symptomatic single or multiple gallstones should be assessed as unfit. A fit assessment may be considered following gallstone removal.

(d) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease may be assessed as fit provided that the disease is stable and not likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(e) Peptic ulceration

Applicants with peptic ulceration should be assessed as unfit pending full recovery.

(f) Abdominal surgery

(1) Abdominal surgery as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic and there is only a minimal risk of secondary complication or recurrence.

(2) Applicants who have undergone a surgical operation on the digestive tract or its adnexa, involving a total or partial excision or a diversion of any of these organs, should be assessed as unfit until such time as the effects of the operation are no longer likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(g) Liver disease

Applicants with morphological or functional liver disease, or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.

AMC2 MED.B.025 Metabolic and endocrine systems

(a) (Metabolic, nutritional or endocrine dysfunction

Metabolic, nutritional or endocrine dysfunction is disqualifying. A fit assessment may be considered if the condition is asymptomatic, clinically compensated and stable.

(b) Obesity

Obese applicants may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the applicable licence(s), Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken with TML of at least 6 months duration or less.

(c) Addison's disease

Applicants with Addison's disease may be assessed as fit provided that cortisone is carried and available for use whilst exercising the privileges of the licence.

(d) Gout

Applicants with acute gout should be assessed as unfit until asymptomatic.

(e) Thyroid dysfunction

Applicants with thyroid disease may be assessed as fit once a stable euthyroid state is attained.

(f) Abnormal glucose metabolism

Glycosuria and abnormal blood glucose levels require investigation. A fit assessment may be considered if normal glucose tolerance is demonstrated (low renal threshold) or impaired glucose tolerance is fully controlled by diet and regularly reviewed.

(g) Diabetes mellitus

Applicants with diabetes mellitus may be assessed as fit. The use of antidiabetic medications that are not likely to cause hypoglycaemia may be acceptable.

Appplicants requiring insulin may be assessed as unfit.

AMC2 MED.B.030 Haematology

(a) Abnormal haemoglobin

Haemoglobin should be tested when clinically indicated.

(b) Anaemia

Applicants with anaemia demonstrated by a reduced haemoglobin level or low haematocrit may be assessed as fit once the primary cause has been treated and the haemoglobin or haematocrit has stabilised at a satisfactory level.

(c) Polycythaemia (Erythrocytosis)

Applicants with polycythaemia (Erythrocytosis) may be assessed as fit if the condition is stable and no associated pathology is demonstrated.

(d) Haemoglobinopathy

Applicants with a haemoglobinopathy may be assessed as fit if minor thalassaemia or other haemoglobinopathy is diagnosed without a history of crises and where full functional capability is demonstrated.

(e) Coagulation and haemorrhagic disorders

Applicants with a coagulation or haemorrhagic disorder may be assessed as fit if there is no likelihood of significant bleeding.

(f) Thrombo-embolic disorders

Applicants with a thrombotic disorder may be assessed as fit if there is no likelihood of significant clotting episodes.

(g) Disorders of the lymphatic system

Applicants with significant enlargement of the lymphatic glands or haematological disease may be assessed as fit if the condition is unlikely to interfere with the safe exercise of the privileges of the applicable licence(s). Applicants may be assessed as fit in cases of acute infectious process which is fully recovered or Hodgkin's lymphoma or other lymphoid malignancy which has been treated and is in full remission.

(h) Leukaemia

(1) Applicants with acute leukaemia may be assessed as fit once in established remission.

(2) Applicants with chronic leukaemia may be assessed as fit after a period of demonstrated stability.

(3) In cases (1) and (2) above there should be no history of central nervous system involvement and no continuing side effects from treatment of flight safety importance. Haemoglobin and platelet levels should be satisfactory. Regular follow- up is required.

(i) Splenomegaly

Applicants with splenomegaly may be assessed as fit if the enlargement is minimal, stable and no associated pathology is demonstrated, or if the enlargement is minimal and associated with another acceptable condition

AMC2 MED.B.035 Genitourinary system

(a) Renal disease

(b) Applicants presenting with renal disease may be assessed as fit if blood pressure is satisfactory and renal function is acceptable. The requirement for dialysis is disqualifying.

(c) Urinary calculi

(1) Applicants presenting with one or more urinary calculi should be assessed as unfit.

(2) Applicants with an asymptomatic calculus or a history of renal colic require investigation.

(3) While awaiting assessment or treatment, a fit assessment with a safety pilot limitation may be considered.

(4) After successful treatment the applicant may be assessed as fit.

(5) Applicants with parenchymal residual calculi may be assessed as fit.

(d) Renal/urological surgery

(1) Applicants who have undergone a major surgical operation on the urinary tract or the urinary apparatus involving a total or partial excision or a diversion of any of its organs should be assessed as unfit until such time as the effects of the operation are no longer likely to cause incapacity in flight. After other urological surgery, a fit assessment may be considered if the applicant is completely asymptomatic, there is minimal risk of secondary complication or recurrence presenting with renal disease, if blood pressure is satisfactory and renal function is acceptable. The requirement for dialysis is disqualifying.

(2) An applicant with compensated nephrectomy without hypertension or uraemia may be assessed as fit.

(3) Applicants who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and with only minimal immuno-suppressive therapy.

(4) Applicants who have undergone total cystectomy may be considered for a fit assessment if there is satisfactory urinary function, no infection and no recurrence of primary pathology.

AMC2 MED.B.040 Infectious disease

(a) Tuberculosis

(1) Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy.

(2) Applicants with quiescent or healed lesions may be assessed as fit. Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.

(b) HIV positivity

Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)

AMC2 MED.B.045 Obstetrics and gynaecology

(a) Gynaecological surgery

An applicant who has undergone a major gynaecological operation should be assessed as unfit until recovery is complete, the applicant is asymptomatic and the effects of the operation are not likely to interfere with the safe exercise of the privileges of the licence(s).

(b) Pregnancy

(1) A pregnant licence holder may be assessed as fit during the first 26 weeks of gestation following satisfactory obstetric evaluation.

(2) Licence privileges may be resumed upon satisfactory confirmation of full recovery following confinement or termination of pregnancy.

AMC2 MED.B.050 Musculoskeletal system

(a) An applicant with any significant sequela from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery should require full evaluation prior to fit assessment.

(b) In cases of limb deficiency, a fit assessment may be considered following a satisfactory medical flight test.

(c) An applicant with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit, provided the condition is in remission and the applicant is taking no disqualifying medication and has satisfactorily completed a medical flight test. A limitation to specified aircraft type(s) may be required.

(d) Abnormal physique or muscular weakness may require a satisfactory medical flight test.

A limitation to specified aircraft type(s) may be required.

AMC2 MED.B.055 Mental Health

Mental health assessment as part of class 2 aero-medical examination

(1) A mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.

(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.

(3) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.

(4) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).

Assessment of holders of a class 2 medical certificate

Assessment of holders of a class 2 medical certificate may require psychiatric and psychological evaluation as determined by the AME, AeMC or DGCA medical assessor. Follow-up, as necessary, should be determined in consultation with the DGCA medical assessor.

(a) Psychotic disorder

A history, or the occurrence, of a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if in certain rare cases a cause can be unequivocally identified as one which is transient, has ceased and will not recur.

(b) Psychotropic substances

Use or abuse of psychotropic substances likely to affect flight safety is disqualifying. If a stable maintenance psychotropic medication is confirmed, a fit assessment with an OSL limitation may be considered.

(c) Schizophrenia, schizotypal or delusional disorder

An applicant with a history of schizophrenia, schizotypal or delusional disorder may only be considered fit if the original diagnosis was inappropriate or inaccurate as confirmed by psychiatric evaluation or, in the case of a single episode of delirium, provided that the applicant has suffered no permanent impairment.

(d) Disorders due to alcohol or other substance use

(1) Mental or behavioural disorders due to alcohol or other substance use, with or without dependency, are disqualifying.

(2) A fit assessment may be considered in consultation with the Kuwait DGCA after a period of two years documented sobriety or freedom from substance use. A fit assessment may be considered earlier with an OSL or OPL limitation. Depending on the individual case, treatment and review may include:

in-patient treatment of some weeks followed by:

(A) review by a psychiatric specialist; and

(B) ongoing review, including blood testing and peer reports, which may be required indefinitely.

(C) .

(e) History of a single or repeated acts of self-harm should be assessed as unfit.

(f) Personality or behavioural disorders

Where there are signs or is established evidence that an applicant may have a personality or behavioural disorder, the applicant should be referred for psychiatric opinion and advice.

(g) Neurotic, stress-related or somatoform disorder

Where there are signs or is established evidence that an applicant may have a neurotic, stress-related or somatoform disorder, the applicant should be referred for psychiatric opinion and advice.

GM1 MED.B.055 Mental health

(a) The mental health assessment for class 2 applicants should include assessment and documentation of:

(1) general attitudes to mental health, including understanding possible indications of reduced mental health in themselves and others;

(2) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;

(3) childhood behavioural problems;

(4) interpersonal and relationship issues, including difficulties with relatives, friends, and work colleagues;

(5) current work and life stressors, including difficulties with aviation operational environment; and

(6) overt personality disorders.

(b) In regard to symptoms of concern and aspects to be taken into consideration when conducting mental health examination for class 2 applicants, guidance presented in GM1 MED.B.055 should be used.

GM2 MED.B.055 Mental health

Drugs and alcohol screening tests used should:

(a) provide information regarding medium-term consumption;

(b) be accepted on national level by the competent authority based on the availability and suitability with the scope mentioned in GM2 MED.B.055(a) above.

AMC2 MED.B.060 Psychology

Applicants with a psychological disorder may need to be referred for psychological or neuropsychiatric opinion and advice ,which may include collection of biological data, aptitude test, personality test and psychological interview.

AMC2 MED.B.065 Neurology

(a) Epilepsy

An applicant may be assessed as fit if:

(1) there is a history of a single afebrile epileptiform seizure, considered to have a very low risk of recurrence;

(2) there has been no recurrence after at least 10 years off treatment;

(3) there is no evidence of continuing predisposition to epilepsy.

(b) Conditions with a high propensity for cerebral dysfunction

An applicant with a condition with a high propensity for cerebral dysfunction should be assessed as unfit. A fit assessment may be considered after full evaluation.

(c) Neurological disease

Any stationary or progressive disease of the nervous system which has caused or is likely to cause a significant disability is disqualifying. In case of minor functional loss associated with stationary disease, a fit assessment may be considered after full evaluation.

(d) Head injury

An applicant with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury may be assessed as fit if there has been a full recovery and the risk of epilepsy is sufficiently low.

(e) Migraine

Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, and therapy. Appropriate limitation(s) may apply.

(f) Spinal or peripheral nerve injury

Applicants with a history or diagnosis of spinal or peripheral nerve injury or a disorder of the nervous system due to a traumatic injury should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC2 MED.B.050 are satisfied.

(g) Vascular deficiencies

Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the provisions of

AMC2 MED.B.050 are met. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.

AMC2 MED.B.070 Visual system

(a) Eye examination

(1) At each aero-medical revalidation examination an assessment of the visual fitness of the licence holder should be undertaken and the eyes should be examined with regard to possible pathology. Conditions which indicate further ophthalmological examination include, but are not limited to, a substantial decrease in the uncorrected visual acuity, any decrease in best corrected visual acuity and/or the occurrence of eye disease, eye injury, or eye surgery.

(6) At the initial assessment, the examination should include:

(i) history;

(ii) visual acuities - near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(iii) examination of the external eye, anatomy, media and fundoscopy;

(iv) ocular motility;

(v) binocular vision;

(vi) colour vision and visual fields;

(vii) further examination on clinical indication.

(7) At the initial assessment the applicant should submit a copy of the recent spectacle prescription if visual correction is required to meet the visual requirements.

(b) Routine eye examination

A routine eye examination should include:

(1) history;

(2) visual acuities - near, intermediate and distant vision (uncorrected and with best optical correction if needed);

(3) examination of the external eye, anatomy, media and fundoscopy;

(4) further examination on clinical indication.

(c) Visual acuity

In an applicant with amblyopia, the visual acuity of the amblyopic eye should be 6/18 (0,3) or better. The applicant may be assessed as fit, provided the visual acuity in the other eye is 6/6 (1,0) or better, with or without correction, and no significant pathology can be demonstrated.

(d) Substandard vision

(1) Reduced stereopsis, abnormal convergence not interfering with near vision and ocular misalignment where the fusional reserves are sufficient to prevent asthenopia and diplopia may be acceptable.

(2) An applicant with substandard vision in one eye may be assessed as fit subject to a satisfactory flight test if the better eye:

(i) achieves distant visual acuity of 6/6 (1,0), corrected or uncorrected;

(ii) achieves intermediate visual acuity of N14 and N5 for near;

(iii) has no significant pathology.

(3) An applicant with a visual field defect may be considered as fit if the binocular visual field is normal and the underlying pathology is acceptable.

(e) Eye surgery

(1) The assessment after eye surgery should include an ophthalmological examination.

(2) After refractive surgery a fit assessment may be considered provided that there is stability of refraction, there are no postoperative complications and no increase in glare sensitivity.

(3) After cataract, retinal or glaucoma surgery a fit assessment may be considered once recovery is complete.

(4) Correcting lenses

Correcting lenses should permit the licence holder to meet the visual requirements at all distances.

AMC2 MED B.075 Colour vision

(a) The Ishihara test (24 plate version) is considered passed if the first 15 plates, presented in a random order, are identified without error.

(b) Those failing the Ishihara test should be examined either by:

(1) anomaloscopy (Nagel or equivalent). This test is considered passed if the colour match is trichromatic and the matching range is 4 scale units or less; or by

(2) lantern testing with a Spectrolux, Beynes or Holmes-Wright lantern. This test is considered passed if the applicant passes without error a test with accepted lanterns.

(c) Colour vision should be tested on clinical indication at revalidation or renewal examinations.

(d) Colour Assessment and Diagnosis (CAD) test. This test is considered passed if the threshold is less than 6 standard normal (SN) units for deutan deficiency, or less than 12 SN units for protan deficiency. A threshold greater than 2 SN units for tritan deficiency indicates an acquired cause which should be investigated.

AMC2 MED.B.080 Otorhino-laryngology

(a) Hearing

(1) The applicant should understand correctly conversational speech when tested with each ear at a distance of 2 metres from and with the applicant's back turned towards the AME.

(2) An applicant with hypoacusis may be assessed as fit if a speech discrimination test or functional cockpit hearing test demonstrates satisfactory hearing ability. An applicant for an instrument rating with hypoacusis should be assessed in consultation with the Kuwait DGCA.

(3) If the hearing requirements can be met only with the use of hearing aids, the hearing aids should provide optimal hearing function, be well tolerated and suitable for aviation purposes.

(b) Examination

An ear, nose and throat (ENT) examination should form part of all initial, revalidation and renewal examinations.

(c) Ear conditions

(1) An applicant with an active pathological process, acute or chronic, of the internal or middle ear should be assessed as unfit until the condition has stabilised or there has been a full recovery.

(2) An applicant with an unhealed perforation or dysfunction of the tympanic membranes should be assessed as unfit. An applicant with a single dry perforation of non-infectious origin which does not interfere with the normal function of the ear may be considered for a fit assessment

(3) Vestibular disturbance

An applicant with disturbance of vestibular function should be assessed as unfit pending full recovery.

(4) Sinus dysfunction

An applicant with any dysfunction of the sinuses should be assessed as unfit pending full recovery.

(d) Oral/upper respiratory tract infections

A significant acute or chronic infection of the oral cavity or upper respiratory tract is disqualifying until full recovery.

(e) Speech disorder

A significant disorder of speech or voice should be disqualifying.

(f) Air passage restrictions

An applicant with significant restriction of the nasal air passage on either side, or significant malformation of the oral cavity or upper respiratory tract may be assessed as fit if ENT evaluation is satisfactory.

(g) Eustachian tube function

An applicant with significant dysfunction of the Eustachian tubes may be assessed as fit in consultation with the Kuwait DGCA.

(h) Sequelae of surgery of the internal or middle ear

Applicants with sequelae of surgery of the internal or middle ear should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.

AMC2 MED.B.085 Dermatology

In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment can be considered.

AMC MED.B.090 Oncology

(a) Applicants may be considered for a fit assessment after treatment for malignant disease if:

(1) there is no evidence of residual malignant disease after treatment;

(2) time appropriate to the type of tumour has elapsed since the end of treatment;

(3) the risk of in-flight incapacitation from a recurrence or metastasis is sufficiently low;

(4) there is no evidence of short or long-term sequelae from treatment that may adversely affect flight safety;

(5) special attention is paid to applicants who have received anthracyline chemotherapy;

(6) arrangements for an oncological follow-up have been made for an appropriate period of time.

(b) Applicants with pre-malignant conditions of the skin may be assessed as fit if treated or excised as necessary and there is a regular follow-up.

(c) Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.

Section 3 - Specific Requirements for LAPL Medical Certificates

AMC1 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates

When a specialist evaluation is required under this section, the aero-medical assessment of the applicant should be performed by an AeMC, or AME or, in the case of AMC 5(d), by the Kuwait DGCA.

AMC2 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Cardiovascular system)

(a) Examination

Pulse and blood pressure should be recorded at each examination.

(b) General

(1) Cardiovascular risk factor assessment

An accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) requires cardiovascular evaluation.

(2) Aortic aneurysm

Applicants with an aortic aneurysm may be assessed as fit subject to satisfactory cardiological evaluation and a regular follow-up.

(3) Cardiac valvular abnormalities

Applicants with a cardiac murmur may be assessed as fit if the murmur is assessed as being of no pathological significance.

(4) Valvular surgery

After cardiac valve replacement or repair a fit assessment may be considered if post-operative cardiac function and investigations are satisfactory with an ORL . Anticoagulation, if needed, should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.

(5) Other cardiac disorders:

(i) Applicants with other cardiac disorders may be assessed as fit subject to satisfactory cardiological assessment with an ORL.

(ii) Applicants with symptomatic hypertrophic cardiomyopathy should be assessed as unfit.

(c) Blood pressure

(1) When the blood pressure consistently exceeds 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment, the applicant should be assessed as unfit.

(2) The initiation of medication for the control of blood pressure should require a period of temporary suspension of the medical certificate to establish the absence of significant side effects.

(d) Coronary artery disease

(1) Applicants with suspected myocardial ischaemia should be investigated before a fit assessment can be considered.

(2) Applicants with angina pectoris requiring medication for cardiac symptoms should be assessed as unfit.

(3) After an ischaemic cardiac event, including myocardial infarction or revascularisation, applicants without symptoms should have reduced any vascular risk factors to an appropriate level. Medication, when used to control cardiac symptoms, is not acceptable. All applicants should be on acceptable secondary prevention treatment.

(4) In cases under (1), (2) and (3) above, applicants who have had a satisfactory cardiological evaluation to include an exercise test or equivalent that is negative for ischaemia may be assessed as fit.

(e) Rhythm and conduction disturbances

(1) Applicants with a significant disturbance of cardiac rhythm or conduction should be assessed as unfit unless a cardiological evaluation concludes that the disturbance is not likely to interfere with the safe exercise of the privileges of the LAPL. A fit assessment may be considered, with an ORL if anticoagulation is needed. Anticoagulation should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.

(2) Pre-excitation

Applicants with ventricular pre-excitation may be assessed as fit subject to satisfactory cardiological evaluation. Applicants with ventricular pre-excitation associated with a significant arrhythmia should be assessed as unfit.

(3) Pacemaker

A fit assessment may be considered subject to satisfactory cardiological evaluation.

(4) Automatic implantable defibrillating system

Applicants with an automatic implantable defibrillating system should be assessed as unfit.

AMC3 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Respiratory system)

(a) Asthma and chronic obstructive airways disease

Applicants with asthma or minor impairment of pulmonary function may be assessed as fit if the condition is considered stable with satisfactory pulmonary function and medication is compatible with flight safety. Systemic steroids may be disqualifying depending on dosage needed and corresponding side effects.

(b) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Investigation should be undertaken with respect to the possibility of systemic involvement. A fit assessment may be considered once the disease is inactive.

(2) Applicants with cardiac sarcoidosis should be assessed as unfit.

(c) Pneumothorax

(1) Applicants with spontaneous pneumothorax may be assessed as fit subject to satisfactory respiratory evaluation following full recovery from a single spontaneous pneumothorax or following recovery from surgical treatment for a recurrent pneumothorax.

(2) Applicants with traumatic pneumothorax may be assessed as fit following full recovery.

(d) Thoracic surgery

Applicants who have undergone major thoracic surgery may be assessed as fit following full recovery.

(e) Sleep apnoea syndrome/sleep disorder

Applicants with unsatisfactorily treated sleep apnoea syndrome should be assessed as unfit.

AMC4 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Digestive system)

(a) Gallstones

Applicants with symptomatic gallstones should be assessed as unfit. A fit assessment may be considered following gallstone removal.

(b) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease may be assessed as fit provided that the disease is stable and not likely to interfere with the safe exercise of the privileges of the licence.

(c) Abdominal surgery

Applicants who have undergone a surgical operation on the digestive tract or its adnexae may be assessed as fit provided recovery is complete, they are asymptomatic and there is only a minimal risk of secondary complication or recurrence.

(d) Pancreatitis

Applicants with pancreatitis may be assessed as fit after satisfactory recovery.

(e) Liver disease

Applicants with morphological or functional liver disease or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.

AMC5 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Metabolic and endocrine systems)

(a) Metabolic, nutritional or endocrine dysfunction

Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit subject to demonstrated stability of the condition and satisfactory aero-medical evaluation.

(b) Obesity

(1) Obese applicants may be assessed as fit if the excess weight is not likely to interfere with the safe exercise of the licence. Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken with TML of at least 6 months duration.

(c) Thyroid dysfunction

Applicants with thyroid disease may be assessed as fit once a stable euthyroid state is attained.

(d) Diabetes mellitus

(1) The use of antidiabetic medications that are not likely to cause hypoglycaemia should be acceptable for a fit assessment.

(2) Applicants with diabetes mellitus Type 1 should be assessed as unfit.

(3) **Applicants with diabetes mellitus Type 2 treated with insulin** may be assessed as fit with limitations for revalidation (only be special application request and approval by the Aviation Safety Director and under strict supervision by DGCA Medical Assessor)if blood sugar control has been achieved and the process under (e) and (f) below is followed. An OSL limitation is required. A TML limitation for 12 months may be needed to ensure compliance with the follow-up requirements below. Licence privileges should be restricted to some light aeroplanes and sailplanes only.

(e) Aero-medical assessment by, or under the guidance of, the Kuwait DGCA:

(1) A diabetology review at yearly intervals, including:

(i) symptom review;

(ii) review of data logging of blood sugar;

(iii) cardiovascular status. Exercise ECG at age 40, at 5-yearly intervals thereafter and on clinical indication, including an accumulation of risk factors;

(iv) nephropathy/ nephropathy status.

(2) Ophthalmological review at yearly intervals, including:

(i) visual fields Humphrey-perimeter;

(ii) retinas full dilatation slit lamp and documentation;

(iii) cataract clinical screening.

The development of retinopathy requires a full ophthalmological review.

(3) Blood testing at 6-monthly intervals:

(i) HbA1c; target is 7,5–8,5 %;

(ii) renal profile;

(iii) liver profile;

(iv) lipid profile.

(4) Applicants should be assessed as temporarily unfit after:

(i) changes of medication/insulin leading to a change to the testing regime until stable blood sugar control can be demonstrated;

(ii) a single unexplained episode of severe hypoglycaemia until stable blood sugar control can be demonstrated.

(5) Applicants should be assessed as unfit in the following cases:

(i) loss of hypoglycaemia awareness;

(ii) development of retinopathy with any visual field loss;

(iii) significant nephropathy;

(iv) any other complication of the disease where flight safety may be jeopardised.

(f) Pilot responsibility

Blood sugar testing is carried out during non-operational and operational periods. A whole blood glucose measuring device with memory should be carried and used. Equipment for continuous glucose monitoring (CGMS) should not be used. Pilots should prove to the AME or AeMC or the Kuwait DGCA that testing has been performed as indicated below and with which results.

(1) Testing during non-operational periods: normally 3–4 times/day or as recommended by the treating physician, and on any awareness of hypoglycaemia.

(2) Testing frequency during operational periods:

(i) 120 minutes before departure;

(ii) <30 minutes before departure;

(iii) 60 minutes during flight;

(iv) 30 minutes before landing.

(3) Actions following glucose testing:

(i) 120 minutes before departure: if the test result is >15 mmol/l, piloting should not be commenced.

(ii) 10–15g of carbohydrate should be ingested and a re-test performed within 30 minutes if:

(A) any test result is <4,5 mmol/l;

(B) the pre-landing test measurement is missed or a subsequent go-around/diversion is performed.

4) All results of blood sugar testing before,during flights and any action following glucose testing shall be available and reported during any subsequent medical certificate examination.

GM1 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Diabetes mellitus Type 2 treated with insulin)

(a) Pilots and their treating physician should be aware that if the HbA1c target level was set to normal (non-diabetic) levels, this will significantly increase the chance of hypoglycaemia. For safety reasons the target level of HbA1c is therefore set to 7.5–8.5 % even though there is evidence that lower HbA1c levels are correlated with fewer diabetic complications.

(b) The safety pilot should be briefed pre-flight on the potential condition of the pilot. The results of blood sugar testing before and during flight should be shared with the safety pilot for the acceptability of the values obtained.

AMC6 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Haematology)

Applicants with a haematological condition, such as:

(a) abnormal haemoglobin including, but not limited to, anaemia, polycythaemia or haemoglobinopathy;

(b) coagulation, haemorrhagic or thrombotic disorder;

(c) significant lymphatic enlargement;

(d) acute or chronic leukaemia;

(e) enlargement of the spleen;

may be assessed as fit subject to satisfactory aero-medical evaluation.

AMC7 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Genitourinary system)

(a) Applicants with a genitourinary disorder, such as:

(1) renal disease; or

(2) one or more urinary calculi, or a history of renal colic;

may be assessed as fit subject to satisfactory renal/urological evaluation.

(b) Applicants who have undergone a major surgical operation in the urinary apparatus may be assessed as fit following full recovery.

(c) Applicants who have undergone renal transplantation may be assessed as fit subject to satisfactory renal evaluation.

AMC8 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Infectious disease)

Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)

Applicants with other chronic infections may be assessed as fit provided the infections are not likely to interfere with the safe exercise of the privileges of the licence.

AMC9 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Obstetrics and gynaecology)

(a) Pregnancy

Holders of a LAPL medical certificate should only exercise the privileges of their licences until the 26th week of gestation under routine antenatal care.

(b) Applicants who have undergone a major gynaecological operation may be assessed as fit after full recovery.

AMC10 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Musculoskeletal system)

Applicants should have satisfactory functional use of the musculoskeletal system to enable the safe exercise of the privileges of the licence.

AMC11 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Psychiatry) Mental health

(a) At revalidation applicants with a mental or behavioural disorder due to alcohol or other substance use should be assessed as unfit pending recovery after a period of two years of documented sobriety or and freedom from substance use and subject to satisfactory psychiatric evaluation after treatment .

(b) Applicants with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder should be assessed as unfit.

(c) Psychotropic substances

Use or abuse of psychotropic substances likely to affect flight safety should be disqualifying. If a stable maintenance psychotropic medication is confirmed, a fit assessment with an appropriate limitation may be considered.

(d) Applicants with a psychiatric condition, such as:

(1) mood disorder;

(2) neurotic disorder;

(3) personality disorder;

(4) mental or behavioural disorder

should undergo satisfactory psychiatric evaluation before a fit assessment may be considered.

(e) Applicants with a history of significant or repeated acts of deliberate self-harm should undergo satisfactory psychiatric and/or psychological evaluation before a fit assessment can be considered.

(Psychology)

Applicants with a psychological disorder may need to be referred for psychological opinion and advice. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased, and the risk of recurrence is minimal.

AMC12 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Neurology)

(a) Epilepsy and seizures

(1) Applicants with an established diagnosis of and under treatment for epilepsy should be assessed as unfit. A re-assessment after all treatment has been stopped for at least 5 years should include a neurological evaluation.

(2) Applicants may be assessed as fit if:

(i) there is a history of a single afebrile epileptiform seizure considered to have a very low risk of recurrence; and

(ii) there has been no recurrence after at least 5 years off treatment; or

(iii) a cause has been identified and treated and there is no evidence of continuing predisposition to epilepsy.

(b) Neurological disease

(1) Applicants with any stationary or progressive disease of the nervous system which has caused or is likely to cause a significant disability should be assessed as unfit. The AME or AeMC should assess these applicants taking into account the privileges of the licence held and the risk involved. An OPL limitation may be appropriate if a fit assessment is made.

(2) In case of minor functional loss associated with stationary disease, a fit assessment may be considered after full evaluation.

(c) Head injury

Applicants with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury may be assessed as fit if there has been a full recovery and the risk of epilepsy is sufficiently low.

(d) Spinal or peripheral nerve injury

Applicants with a history or diagnosis of spinal or peripheral nerve injury may be assessed as fit if neurological review and musculoskeletal assessments are satisfactory.

(e) Migraine

Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, therapy. Appropriate limitation(s) may apply.

(f) Vascular deficiencies

Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.

AMC13 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Visual system)

(a) Applicants should not possess any abnormality of the function of the eyes or their adnexa or any active pathological condition, congenital or acquired, acute or chronic, or any sequelae of eye surgery or trauma, which is likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(b) Eye examination

The examination should include visual acuities (near, intermediate and distant vision) and visual field.

(c) Visual acuity

(1) Visual acuity with or without corrective lenses should be 6/9 (0.7) binocularly and 6/12 (0,5) in each eye.

(2) Applicants who do not meet the required visual acuity should be assessed by an AME or AeMC, taking into account the privileges of the licence held and the risk involved.

(3) Applicants should be able to read an N5 chart (or equivalent) at 30–50cms and an N14 chart (or equivalent) at 100cms, with correction if prescribed.

(d) Substandard vision

Applicants with substandard vision in one eye may be assessed as fit if the better eye:

(1) achieves distant visual acuity of 6/6 (1,0), corrected or uncorrected;

(2) achieves distant visual acuity less than 6/6 (1,0) but not less than 6/9 (0,7), after ophthalmological evaluation.

(e) Visual field defects

Applicants with a visual field defect may be assessed as fit if the binocular visual field or monocular visual field is normal.

(f) Eye surgery

(1) After refractive surgery, a fit assessment may be considered, provided that there is stability of refraction, there are no post-operative complications and no significant increase in glare sensitivity.

(2) After cataract, retinal or glaucoma surgery a fit assessment may be considered once recovery is complete.

(g) Correcting lenses

Correcting lenses should permit the licence holder to meet the visual requirements at all distances.

AMC14 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Colour vision)

Applicants for a night rating should correctly identify 9 of the first 15 plates of the 24-plate edition of Ishihara pseudoisochromatic plates or should be colour safe.

AMC15 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Otorhino-laryngology)

(a) Hearing

(1) Applicants should understand correctly conversational speech when tested at a distance of 2 metres from and with the applicant's back turned towards the examiner.

(2) Applicants with hypoacusis should demonstrate satisfactory functional hearing ability.

(3) If the hearing requirements can only be met with the use of hearing aid(s), the hearing aid(s) should provide optimal hearing function, be well-tolerated, and be suitable for aviation purposes.

(b) Ear conditions

Applicants for a LAPL medical certificate with:

(1) an active pathological process, acute or chronic, of the internal or middle ear;

(2) unhealed perforation or dysfunction of the tympanic membrane(s);

(3) disturbance of vestibular function;

(4) significant restriction of the nasal passages;

(5) sinus dysfunction;

(6) significant malformation or significant, acute or chronic infection of the oral cavity or upper respiratory tract; or

(6) significant disorder of speech or voice;

should undergo further medical examination and assessment to establish that the condition does not interfere with the safe exercise of the privileges of the licence.

AMC16 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Dermatology)

In cases where a dermatological condition is associated with a systemic disease, full consideration should be given to the underlying illness before a fit assessment may be considered.

AMC17 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Oncology)

(a) In the case of malignant disease, applicants may be considered for a fit assessment if:

(1) there is no evidence of residual malignant disease likely to jeopardise flight safety;

(2) time appropriate to the type of tumour has elapsed since the end of primary treatment;

(3) the risk of in-flight incapacitation from a recurrence or metastasis is sufficiently low;

(4) there is no evidence of short or long-term sequelae from treatment that may adversely affect flight safety.

(b) Arrangements for an oncological follow-up should be made for an appropriate period of time.

(c) Applicants with an established history or clinical diagnosis of intracerebral malignant tumour should be assessed as unfit.

Subpart C - Requirements for Medical Fitness of Cabin Crew

Section 1 - General requirements

AMC1 MED.C.005 Aero-medical assessments

(a) When conducting aero-medical examination and/or assessments of cabin crew, their medical fitness should be assessed with particular regard to their physical and mental ability to:

(1) undergo the training required for cabin crew to acquire and maintain competence, e.g. actual fire-fighting, slide descending, using Protective Breathing Equipment (PBE) in a simulated smoke-filled environment, providing first aid;

(2) manipulate the aircraft systems and emergency equipment to be used by cabin crew, e.g. cabin management systems, doors/exits, escape devices, fire extinguishers, taking also into account the type of aircraft operated e.g. narrow- bodied or wide-bodied, single/multi-deck, single/multi-crew operation;

(3) continuously sustain the aircraft environment whilst performing duties, e.g. altitude, pressure, re-circulated air, noise; and the type of operations such as short/medium/long/ultralong haul; and

(4) perform the required duties and responsibilities efficiently during normal and abnormal operations, and in emergency situations and psychologically demanding circumstances e.g. assistance to crew members and passengers in case of decompression; stress management, decision-making, crowd control and effective crew coordination, management of disruptive passengers and of security threats. When relevant, operating as single cabin crew should also be taken into account when assessing the medical fitness of cabin crew.

(b) Intervals

(1) The interval between aero-medical assessments should be determined by the DGCA/ASD. The intervals established by the competent authority apply to cabin crew members who:

(i) undergo aero-medical assessments by an AM or AeMC under the oversight of DGCA/ASD; or

(ii) are employed by an operator under the oversight of DGCA/ASD.

(2) The interval between aero-medical assessments may be reduced by the AME or AeMC for medical reasons and in accordance with MED.C.035.

(3) Aero-medical assessments for the revalidation of a cabin crew medical report may be undertaken up to 45 days prior to the expiry date of the previous medical report. The validity period of the aero-medical assessment should be calculated from the expiry date of the previous aero-medical assessment.

Section 2 - Requirements for aero-medical assessment of cabin crew

AMC1 MED.C.025 Content of aero-medical assessments

Aero-medical examinations and/or assessments of cabin crew members should be conducted according to the specific medical requirements in AMC2 to AMC18 MED.C.025.

AMC2 MED.C.025 Content of aero-medical assessments (Cardiovascular system)

(a) Examination

(1) A standard 12-lead resting electrocardiogram (ECG) and report should be completed at initial issue, on clinical indication, at the first examination after the age of 40 and then at least every five years after the age of 50. If cardiovascular risk factors such as smoking, abnormal cholesterol levels or obesity are present, the intervals of resting ECGs should be reduced to two years.

(7) Extended cardiovascular assessment should be required when clinically indicated.

(b) Cardiovascular system - general

(1) Cabin crew members with any of the following conditions:

(i) aneurysm of the thoracic or supra-renal abdominal aorta, before surgery;

(ii) significant functional abnormality of any of the heart valves; or

(iii) heart or heart/lung transplantation

should be assessed as unfit.

(2) Cabin crew members with an established diagnosis of one of the following conditions:

(i) peripheral arterial disease before or after surgery;

(ii) aneurysm of the abdominal aorta, before or after surgery;

(iii) minor cardiac valvular abnormalities;

(iv) after cardiac valve surgery;

(v) abnormality of the pericardium, myocardium or endocardium;

(vi) congenital abnormality of the heart, before or after corrective surgery;

(vii) a cardiovascular condition requiring systemic anticoagulant therapy;

(viii) recurrent vasovagal syncope of uncertain cause ;

(ix) arterial or venous thrombosis; or

(x) pulmonary embolism

should be evaluated by a cardiologist before a fit assessment can be considered.

For recurrent vasovagal syncope fit assessment may be considered after a 6-month period without recurrence, provided cardiological evaluation is satisfactory. Neurological review may be indicated.

(c) Blood pressure

Blood pressure should be recorded at each examination.

(1) The blood pressure should be within normal limits of 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment.

(2) The initiation of medication for the control of blood pressure should require a period of temporary suspension of fitness to establish the absence of any significant side effects.

(d) Coronary artery disease

(1) Cabin crew members with:

(i) cardiac ischaemia;

(ii) symptomatic coronary artery disease; or

(iii) symptoms of coronary artery disease controlled by medication

should be assessed as unfit.

(2) Cabin crew members who are asymptomatic after myocardial infarction or surgery for coronary artery disease should have fully recovered before a fit assessment can be considered.

(e) Rhythm/conduction disturbances

(1) Cabin crew members with any significant disturbance of cardiac conduction or rhythm should undergo cardiological evaluation before a fit assessment can be considered.

(2) Cabin crew members with a history of:

(i) ablation therapy; or

(ii) pacemaker implantation

should undergo satisfactory cardiovascular evaluation before a fit assessment can be made.

(8) Cabin crew members with:

(i) symptomatic sinoatrial disease;

(ii) complete atrioventricular block;

(iii) symptomatic QT prolongation;

(iv) an automatic implantable defibrillating system; or

(v) a ventricular anti-tachycardia pacemaker

should be assessed as unfit.

(f) Thromboembolic disorders

Whilst anticoagulation therapy is initiated, cabin crew members should be assessed as unfit. After a period of stable anticoagulation, a fit assessment may be considered with limitation(s), as appropriate. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range and the haemorrhagic risk is acceptable.

AMC3 MED.C.025 Content of aero-medical assessments (Respiratory system)

Cabin crew members with significant impairment of pulmonary function should be assessed as unfit. A fit assessment may be considered once pulmonary function has recovered and is satisfactory.

(a) Cabin crew members should be required to undergo pulmonary function tests on clinical indication.

(b) Cabin crew members with a history or established diagnosis of:

(1) asthma;

(2) active inflammatory disease of the respiratory system;

(3) active sarcoidosis;

(4) pneumothorax;

(5) sleep apnoea syndrome/sleep disorder; or

(6) major thoracic surgery

should undergo respiratory evaluation with a satisfactory result before a fit assessment can be considered.

(c) Cabin crew members who have undergone a pneumonectomy should be assessed as unfit, and may be assessed as fit after 6 weeks following full recovery and full respiratory evaluation.

AMC4 MED.C.025 Content of aero-medical assessments (Digestive system)

(a) Cabin crew members with any sequelae of disease or surgical intervention in any part of the digestive tract or its adnexa likely to cause incapacitation in flight, in particular any obstruction due to stricture or compression, should be assessed as unfit.

(b) Cabin crew members should be free from herniae that might give rise to incapacitating symptoms.

(c) Cabin crew members with disorders of the gastro-intestinal system, including:

(1) recurrent dyspeptic disorder including peptic ulcer requiring medication;

(2) pancreatitis;

(3) symptomatic gallstones;

(4) an established diagnosis or history of chronic inflammatory bowel disease; or

(5) after surgical operation on the digestive tract or its adnexa, including surgery involving total or partial excision or a diversion of any of these organs

(6) morphological or functional liver disease; including liver transplantation

may be assessed as fit subject to satisfactory evaluation after successful treatment and full recovery after surgery.

AMC5 MED.C.025 Content of aero-medical assessments (Metabolic and endocrine systems)

(a) Cabin crew members should not possess any functional or structural metabolic, nutritional or endocrine disorder which is likely to interfere with the safe exercise of their duties and responsibilities.

(b) Cabin crew members with metabolic, nutritional or endocrine dysfunction may be assessed as fit, subject to demonstrated stability of the condition and satisfactory aero- medical evaluation.

(c) Diabetes mellitus

(1) Cabin crew members with diabetes mellitus requiring insulin may be assessed as fit if it can be demonstrated that adequate blood sugar control has been achieved and hypoglycaemia awareness is established and maintained. Limitations should be imposed as appropriate. A requirement to undergo specific regular medical examinations (SIC) and a restriction to operate only in multi-cabin crew operations should be placed as a minimum.

(2) Cabin crew members with diabetes mellitus not requiring insulin may be assessed as fit if it can be demonstrated that adequate blood sugar control has been achieved and hypoglycaemia awareness, if applicable considering the medication, is achieved.

(d) Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken with TML of at least 12 months duration.

AMC6 MED.C.025 Content of aero-medical assessments (Haematology)

Cabin crew members with a haematological condition, such as:

(a) abnormal haemoglobin including, but not limited to, anaemia, polycythaemia or haemoglobinopathy;

(b) coagulation, haemorrhagic or thrombotic disorder;

(c) significant lymphatic enlargement;

(d) acute or chronic leukaemia; or

(e) enlargement of the spleen

may be assessed as fit subject to satisfactory aero-medical evaluation.

AMC7 MED.C.025 Content of aero-medical assessments (Genitourinary system)

(a) Urine analysis should form part of every aero-medical examination and/or assessment. The urine should not contain any abnormal element(s) considered to be of pathological significance.

(b) Cabin crew members with any sequela of disease or surgical procedures on the kidneys or the urinary tract, in particular any obstruction due to stricture or compression likely to cause incapacitation should be assessed as unfit.

(c) Cabin crew members with a genitourinary disorder, such as:

(1) renal disease; or

(2) a history of renal colic due to one or more urinary calculi;

may be assessed as fit subject to satisfactory renal/urological evaluation.

(d) Cabin crew members who have undergone a major surgical operation in the urinary apparatus involving a total or partial excision or a diversion of its organs should be assessed as unfit and be re-assessed after full recovery before a fit assessment can be made.

(e) Cabin crew members who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and tolerated with only minimal immuno-suppressive therapy after at least 12 months. A requirement to undergo specific medical examinations (SIC) and a restriction to operate only in multi-cabin crew operations (MCL) should be considered.

(f) Cabin crew members requiring dialysis should be assessed as unfit.

AMC8 MED.C.025 Content of aero-medical assessments

INFECTIOUS DISEASE

Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)

AMC9 MED.C.025 Content of aero-medical assessments (Obstetrics and gynaecology)

(a) Cabin crew members who have undergone a major gynaecological operation should be assessed as unfit until full recovery.

(b) Pregnancy

(1) A pregnant cabin crew member may be assessed as fit only during the first 16 weeks of gestation following review of the obstetric evaluation by the AME.

(2) A limitation not to perform duties as single cabin crew member should be considered.

(3) The AME should provide written advice to the cabin crew member and supervising physician regarding potentially significant complications of pregnancy resulting from flying duties.

AMC10 MED.C.025 Content of aero-medical assessments (Musculoskeletal system)

(a) A cabin crew member should have sufficient standing height, arm and leg length and muscular strength for the safe exercise of their duties and responsibilities.

(b) A cabin crew member should have satisfactory functional use of the musculoskeletal system. . Particular attention should be paid to emergency procedures and evacuation, and related training.

(c) Cabin crew members with any significant sequelae from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery require full evaluation prior to a fit assessment.

(d) Cabin crew members with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission or is stable and the affected cabin crew member is not taking any medication that may lead to unfitness.

AMC11 MED.C.025 Content of aero-medical assessments Mental Health

(Psychiatry)

(a) Cabin crew members with a mental or behavioural disorder due to alcohol or other problematic substance use should be assessed as unfit pending recovery and freedom from problematic substance use and subject to satisfactory psychiatric evaluation.

(b) Cabin crew members with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder should be assessed as unfit.

(c) Cabin crew members with a psychiatric condition such as:

(1) mood disorder;

(2) neurotic disorder;

(3) personality disorder; or

(4) mental or behavioural disorder

should undergo satisfactory psychiatric evaluation before a fit assessment can be made.

(d) Cabin crew members with a history of a single or repeated acts of deliberate self-harm should be assessed as unfit. Cabin crew members should undergo satisfactory psychiatric evaluation before a fit assessment can be considered.

(Psychology)

(a) Where there is established evidence that a cabin crew member has a psychological disorder, he/she should be referred for psychological opinion and advice.

(b) The psychological evaluation may include a collection of biographical data, the review of aptitudes, and personality tests and psychological interview.

(c) The psychologist should submit a report to the AME, detailing the results and recommendation.

(d) The cabin crew member may be assessed as fit to perform cabin crew duties, with limitation if and as appropriate.

~~(a) Where there is established evidence that a cabin crew member has a psychological disorder, he/she should be referred for psychological opinion and advice.~~

~~(a) The psychological evaluation may include a collection of biographical data, the review of aptitudes, and personality tests and psychological interview.~~

~~(a) The psychologist should submit a report to the AME, detailing the results and recommendation.~~

~~(a) The cabin crew member may be assessed as fit to perform cabin crew duties, with limitation if and as appropriate.~~

AMC12 MED.C.025 Content of aero-medical assessments (Neurology)

(a) Cabin crew members with an established history or clinical diagnosis of:

(1) epilepsy; or

(2) recurring episodes of disturbance of consciousness of uncertain cause

should be assessed as unfit.

(b) Cabin crew members with an established history or clinical diagnosis of:

(1) epilepsy without recurrence after five years of age and without treatment for more than ten years;

(2) epileptiform EEG abnormalities and focal slow waves;

(3) progressive or non-progressive disease of the nervous system;

(4) a single episode of disturbance of consciousness of uncertain cause;

(5) loss of consciousness after head injury;

(6) penetrating brain injury; or

(7) spinal or peripheral nerve injury

should undergo further evaluation before a fit assessment can be considered.

(c) Cabin crew members with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological review and musculoskeletal assessments are satisfactory.

AMC13 MED.C.025 Content of aero-medical assessments (Visual System)

(a) Examination

(1) a routine eye examination should form part of the initial and all further assessments and/or examinations; and

(2) an extended eye examination should be undertaken when clinically indicated.

(b) Distant visual acuity, with or without correction, should be with both eyes 6/9 or better.

(c) A cabin crew member should be able to read an N5 chart (or equivalent) at 30–50 cm, with correction if prescribed.

(d) Cabin crew members should be required to have normal fields of vision and normal binocular function.

(e) Cabin crew members who have undergone refractive surgery may be assessed as fit subject to satisfactory ophthalmic evaluation.

(f) Cabin crew members with diplopia should be assessed as unfit.

(g) Spectacles and contact lenses:

If satisfactory visual function is achieved only with the use of correction:

(1) in the case of myopia, spectacles or contact lenses should be worn whilst on duty;

(2) in the case of hyperopia, spectacles or contact lenses should be readily available for immediate use;

(3) the correction should provide optimal visual function and be well tolerated;

(4) orthokeratologic lenses should not be used.

AMC14 MED.C.025 Content of aero-medical assessments (Colour vision)

Cabin crew members should be able to correctly identify 9 of the first 15 plates of the 24-plate edition of Ishihara pseudoisochromatic plates. Alternatively, cabin crew members should demonstrate that they are colour safe.

AMC15 MED.C.025 Content of aero-medical assessments (Otorhino-laryngology)

(a) Hearing should be satisfactory for the safe exercise of cabin crew duties and responsibilities. Cabin crew with hypoacusis should demonstrate satisfactory functional hearing abilities.

(b) Examination

(1) An ear, nose and throat (ENT) examination should form part of all examinations and/or assessments.

(2) Hearing should be tested at all assessments and/or examinations:

(i) the cabin crew member should understand correctly conversational speech when tested with each ear at a distance of 2 meters from and with the cabin crew member's back turned towards the examiner;

(ii) notwithstanding (i) above, hearing should be tested with pure tone audiometry at the initial examination and when clinically indicated;

(iii) at initial examination the cabin crew member should not have a hearing loss of more than 35 dB at any of the frequencies 500 Hz, 1000 Hz or 2000 Hz, or more than 50 dB at 3000 Hz, in either ear separately.

(c) Cabin crew members with:

(1) an active pathological process, acute or chronic, of the internal or middle ear;

(2) unhealed perforation or dysfunction of the tympanic membrane(s);

(3) disturbance of vestibular function;

(4) significant restriction of the nasal passages;

(5) sinus dysfunction;

(6) significant malformation or significant, acute or chronic infection of the oral cavity or upper respiratory tract;

(7) significant disorder of speech or voice;

should undergo further medical examination and assessment to establish that the condition does not interfere with the safe exercise of their duties and responsibilities.

(8)If the hearing requirements can be met only with the use of hearing aid(s), the hearing aid(s) should provide optimal hearing function, be well-tolerated, and suitable for aviation purposes.

AMC16 MED.C.025 Content of aero-medical assessments (Dermatology)

In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be made.

AMC17 MED.C.025 Content of aero-medical assessments (Oncology)

(a) After treatment for malignant disease, cabin crew members should undergo satisfactory oncological and aero-medical evaluation before a fit assessment may be considered.

(b) Cabin crew members with an established history or clinical diagnosis of intracerebral malignant tumour should be assessed as unfit. Considering the histology of the tumour, a fit assessment may be considered after successful treatment and full recovery.

GM1 MED.C.025 Content of aero-medical assessments

(a) When conducting aero-medical examinations and/or assessments, typical cabin crew duties as listed in (b) and (c), particularly those to be performed during abnormal operations and emergency situations, and cabin crew responsibilities to the travelling public should be considered in order to identify:

(1) any physical and/or mental conditions that could be detrimental to the performance of the duties required from cabin crew; and

(2) which examination(s), test(s) or investigation(s) should be undergone to complete an appropriate aero-medical assessment.

(b) Main cabin crew duties and responsibilities during day-to-day normal operations

(1) During pre/post-flight ground operations with/without passengers on board:

(i) monitoring of situation inside the aircraft cabin and awareness of conditions outside the aircraft including observation of visible aircraft surfaces and information to flight crew of any surface contamination such as ice or snow;

(ii) assistance to special categories of passengers (SCPs) such as infants and children (accompanied or unaccompanied), persons with disabilities or reduced mobility, medical cases with or without medical escort, and inadmissible, deportees and passengers in custody;

(iii) observation of passengers (any suspicious behaviour, passengers under the influence of alcohol and/or drugs, mentally disturbed), observation of potential able-bodied persons, crowd control during boarding and disembarkation;

(iv) safe stowage of cabin luggage, safety demonstrations and cabin secured checks, management of passengers and ground services during re-fuelling, observation of use of portable electronic devices;

(v) preparedness to carry out safety and emergency duties at any time, and security alertness.

(2) During flight:

(i) operation and monitoring of aircraft systems, surveillance of the cabin, lavatories, galleys, crew areas and flight crew compartment;

(ii) coordination with flight crew on situation in the cabin and turbulence events/effects;

(iii) management and observation of passengers (consumption of alcohol, behaviour, potential medical issues), observation of use of portable electronic devices;

(iv) safety and security awareness and preparedness to carry out safety and emergency duties at any time, and cabin secured checks prior to landing.

(c) Main cabin crew duties and responsibilities during abnormal and emergency operations

(1) In case of planned or unplanned emergency evacuation: briefing and/or commands to passengers including SCPs and selection and briefing to able-bodied persons; crowd control monitoring and evacuation conduct including in the absence of command from the flight crew; post-evacuation duties including assistance, first aid and management of survivors and survival in particular environment; activation of applicable communication means towards search and rescue services.

(2) In case of decompression: checking of crew members, passengers, cabin, lavatories, galleys, crew rest areas and flight crew compartment, and administering oxygen to crew members and passengers as necessary.

(3) In case of pilot incapacitation: secure pilot in his/her seat or remove from flight crew compartment; administer first aid and assist operating pilot as required.

(4) In case of fire or smoke: identify source/cause/type of fire/smoke to perform the necessary required actions; coordinate with other cabin crew members and flight crew; select appropriate extinguisher/agent and fight the fire using portable breathing equipment (PBE), gloves, and protective clothing as required; management of necessary passengers movement if possible; instructions to passengers to prevent smoke inhalation/suffocation; give first aid as necessary; monitor the affected area until landing; preparation for possible emergency landing.

(5) In case of first aid and medical emergencies: assistance to crew members and/or passengers; correct assessment and correct use of therapeutic oxygen, defibrillator (if available), first-aid kits/emergency medical kit contents as required; management of events, of incapacitated person(s) and of other passengers; coordination and effective communication with other crew members, in particular when medical advice is transmitted by frequency to flight crew or by a telecommunication connection.

(6) In case of disruptive passenger behaviour: passenger management as appropriate including use of restraint technique as considered required.

(7) In case of security threats (bomb threat on ground or in-flight and/or hijack): control of cabin areas and passengers' management as required by the type of threat, management of suspicious device, protection of flight crew compartment door.

(8) In case of handling of dangerous goods: observing safety procedures when handling the affected device, in particular when handling chemical substances that are leaking; protection and management of self and passengers and effective coordination and communication with other crew members.

Section 3 - Additional Requirements for Applicants for, and Holders of, a Cabin Crew Attestation

AMC1 MED.C.030 Cabin crew medical report

The cabin crew medical report to be provided in writing to the applicants for, and holders of, a cabin crew attestation after completion of each aero-medical assessment should be issued:

(a) in the national language(s) and/or in English; and

(b) according to the format below, or another format if all, and only, the elements specified below are provided.

CABIN CREW MEDICAL REPORT FOR CABIN CREW ATTESTATION (CCA) APPLICANT OR HOLDER		
(1)	State where the aero-medical assessment of the CCA applicant/holder was conducted:	
(2)	Name of CCA applicant/holder:	
(3)	Nationality of CCA applicant/holder:	
(4)	Date and place of birth of CCA applicant/holder: (*dd/mm/yyyy*)	
(5)	Expiry date of the previous aero-medical assessment: (*dd/mm/yyyy*)	
(6)	Date of the aero-medical assessment: (*dd/mm/yyyy*)	
(7)	Aero-medical assessment: (*fit or unfit*)	
(8)	Limitation(s) if applicable:	
(9)	Date of the next required aero-medical assessment: (*dd/mm/yyyy*)	
(10)	Date of issue and signature of the AME, or, who issued the cabin crew medical report:	
(11)	Seal or stamp:	
(12)	Signature of CCA applicant/holder:	

AMC1 MED.C.035 Limitations

When assessing whether the holder of a cabin crew attestation may be able to perform cabin crew duties safely if complying with one or more limitations, the following possible limitations should be considered:

(a) A restriction to operate only in multi-cabin crew operations (MCL);

(b) A restriction to specified aircraft type(s) (OAL) or to a specified type of operation (OOL);

(c) A requirement to undergo the next aero-medical examination and/or assessment at an earlier date than required by MED.C.005(b) (TML);

(d) A requirement to undergo specific regular medical examination(s) (SIC);

(e) A requirement for visual correction (CVL), or by means of corrective lenses only (CCL);

(f) A requirement to use hearing aids (HAL); and

(g) Special restriction as specified (SSL).

Subpart D - Aero-Medical Examiners (AMEs)

AMC1 MED.D.010 Requirements for the issue of an AME certificate

(a) Basic training course for AMEs

The basic training course for AMEs should consist of 60 hours theoretical and practical training, including specific examination techniques.

(b) The syllabus for the basic training course should cover at least the following subjects:

(1) Introduction to aviation medicine;

(2) Physics of atmosphere and space;

(3) Basic aeronautical knowledge;

(4) Aviation physiology;

(5) Ophthalmology, including demonstration and practical;

(6) Otorhinolaryngology, including demonstration and practical;

(7) Cardiology and general medicine;

(8) Neurology;

(9) Psychiatry in aviation medicine;

(10) Psychology;

(11) Dentistry;

(12) Accidents, escape and survival;

(13) Legislation, rules and regulations;

(14) Air evacuation, including demonstration and practical;

(15) Medication and flying.

(16) Respiratory

(17) Metabolic and endocrine systems

(18) Haematology

(19) Genitourinary system

(20) Musculoskeletal system

(21) Oncology

(22) Cabin crew working environment

(23) In-flight environment; and

(24) Space medicine

AMC1 MED.D.015 Requirements for the extension of privileges

(a) Advanced training course for AMEs The advanced training course for AMEs should consist of another 60 hours of theoretical and practical training, including specific examination techniques.

(b) The syllabus for the advanced training course should cover at least the following subjects:

(1) Pilot working environment;

(2) Aerospace physiology, including demonstration and practical;

(3) Ophthalmology, including demonstration and practical;

(4) Otorhinolaryngology, including demonstration and practical;

(5) Cardiology and general medicine, including demonstration and practical;

(6) Neurology/psychiatry, including demonstration and practical;

(7) Human factors in aviation, including demonstration and practical;

(8) Tropical medicine;

(9) Hygiene, including demonstration and practical;

(10) Space medicine.

(11) Practical training in an AeMC should be under the guidance and supervision of the head of the AeMC.

(12) After the successful completion of the practical training, a report of demonstrated competency should be issued.

AMC1 MED.D.030 Validity of AME certificates

Refresher training in aviation medicine

(a) It is the responsibility of the AME to continuously maintain and improve their competencies.

(b) During the period of authorisation, an AME should attend 20 hours of refresher training.

(c) A proportionate number of refresher training hours should be provided by, or conducted under the direct supervision of the competent authority (if available) or by another state acceptable to the Medical Assessor.

(d) Attendance at scientific meetings, congresses and flight deck experience may be approved by the Kuwait DGCA for a specified number of hours against the training obligations of the AME.

(e) Scientific meetings that should be accredited by the Kuwait DGCA are:

(1) International Academy of Aviation and Space Medicine Annual Congresses;

(2) Aerospace Medical Association Annual Scientific Meetings; and

(3) other scientific meetings, as organised or approved by the Medical Assessor.

(f) Other refresher training may consist of:

(1) flight deck experience;

(2) jump seat experience;

(3) simulator experience; and

(4) aircraft piloting.

Subpart E - Medical Requirements for Air Traffic Controllers

GM1.MED.A.020 Decrease in medical fitness

Medication — Guidance for Air Traffic Controllers

(a) Any medication can cause side effects, some of which may impair the safe exercise of the privileges of the licence. Equally, symptoms of colds, sore throats, diarrhoea and other abdominal upsets may cause little or no problem whilst not exercising the privileges of the licence, but may distract the air traffic controller and degrade their performance whilst on duty. Therefore, one issue with medication and the safe exercise of the privileges of the licence is the underlying condition and, in addition, the symptoms may be compounded by the side effects of the medication prescribed or bought over the counter for treatment. This guidance material provides some help to air traffic controllers in deciding whether expert aero-medical advice by an AME, AeMC or Medical Assessor is needed.

(b) Before taking any medication and exercising the privileges of the licence, the following three basic questions should be satisfactorily answered:

(1) Do I feel fit to control?

(9) Do I really need to take medication at all?

(10) Have I given this particular medication a personal trial whilst not exercising the privileges of my licence to ensure that it will not have any adverse effects on my ability to exercise the privileges of my licence?

(c) Confirming the absence of adverse effects may well need expert aero-medical advice.

(d) The following are some widely used medicines with a description of their compatibility with the safe exercise of the privileges of the licence:

(1) Antibiotics. Antibiotics may have short-term or delayed side effects which can affect the performance of the air traffic controller. More significantly, however, their use usually indicates that an infection is present and, thus, the effects of this infection may mean that an air traffic controller is not fit to control and should obtain expert aero-medical advice.

(2) Anti-malaria drugs. The decision on the need for anti-malaria drugs depends on the geographical areas to be visited, and the risk that the air traffic controller has of being exposed to mosquitoes and of developing malaria. An expert medical opinion should be obtained to establish whether anti-malaria drugs are needed and what kind of drugs should be used. Most of the anti-malaria drugs (atovaquone plus proguanil, chloroquine, doxycycline) are compatible with the safe exercise of the privileges of the licence. However, adverse effects associated with mefloquine include insomnia, strange dreams, mood changes, nausea, diarrhoea and headaches. In addition, mefloquine may cause spatial disorientation and lack of fine coordination and is, therefore, not compatible with the safe exercise of the privileges of the licence.

(11) Antihistamines. Antihistamines can cause drowsiness. They are widely used in ‘cold cures’ and in treatment of hay fever, asthma and allergic rashes. They may be in tablet form or a constituent of nose drops or sprays. In many cases, the condition itself may preclude the safe exercise of the privileges of the licence, so that, if treatment is necessary, expert aero-medical advice should

be sought so that so-called non-sedative antihistamines, which do not degrade human performance, can be prescribed.

(12) Cough medicines. Antitussives often contain codeine, dextromethorfan or pseudo-ephedrine which are not compatible with the safe exercise of the privileges of the licence. However, mucolytic agents (e.g. carbocysteine) are well tolerated and are compatible with the safe exercise of the privileges of the licence.

(13) Decongestants. Nasal decongestants with no effect on alertness may be compatible with the safe exercise of the privileges of the licence.

(14) Nasal corticosteroids are commonly used to treat hay fever, and are compatible with the safe exercise of the privileges of the licence.

(15)

(i) Common pain killers and antifebrile drugs. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and paracetamol, commonly used to treat pain, fever or headaches, may be compatible with the safe exercise of the privileges of the licence. However, the air traffic controller should give affirmative answers to the three basic questions in paragraph (b) before using the medication and exercising the privileges of the licence.

(ii) Strong analgesics. The more potent analgesics including codeine are opiate derivatives, and may produce a significant decrement in human performance and, therefore, are not compatible with the safe exercise of the privileges of the licence.

(16) Anti-ulcer medicines. Gastric secretion inhibitors such as H2 antagonists (e.g. ranitidine, cimetidine) or proton pump inhibitors (e.g. omeprazole) may be acceptable after diagnosis of the pathological condition. It is important to seek for the medical diagnosis and not to only treat the dyspeptic symptoms.

(17) Anti-diarrhoeal drugs. Loperamide is one of the more common anti-diarrhoeal drugs and is usually safe to take whilst exercising the privileges of the licence. However, the diarrhoea itself often makes the air traffic controller unable to exercise the privileges of the licence.

(18) Hormonal contraceptives and hormone replacement therapy usually have no adverse effects and are compatible with the safe exercise of the privileges of the licence.

(19) Erectile dysfunction medication. This medication may cause disturbances in colour vision and dizziness. There should be at least six hours between taking sildenafil and exercising the privileges of the licence; and 36 hours between taking vardenafil or tadalafil and exercising the privileges of the licence.

(20) Smoking cessation. Nicotine replacement therapy may be acceptable. However, other medication affecting the central nervous system (buproprion, varenicline) is not acceptable for air traffic controllers.

(21) High blood pressure medication. Most anti-hypertensive drugs are compatible with the safe exercise of the privileges of the licence. However, if the level of blood pressure is such that drug therapy is required, the air traffic controller should be monitored for any side effects before exercising the privileges of the licence. Therefore, consultation with the AME, AeMC or Medical Assessor as applicable, is needed.

(22) Asthma medication. Asthma has to be clinically stable before an air traffic controller can return to exercising the privileges of the licence. The use of respiratory aerosols or powders, such as corticosteroids, beta-2-agonists or chromoglycic acid may be compatible with the safe exercise of the privileges of the licence. However, the use of oral steroids or theophylline derivatives is usually incompatible with the safe exercise of the privileges of the licence. Air traffic controllers using medication for asthma should consult an AME, AeMC, or Medical Assessor, as applicable.

(23) Tranquillisers, anti-depressants and sedatives. The inability to react, due to the use of this group of medicines, together with the underlying condition for which these medications have been prescribed, will almost certainly mean that the mental state of an air traffic controller is not compatible with the safe exercise of the privileges of the licence. Air traffic controllers using tranquillisers, anti-depressants and sedatives should consult an AME, AeMC, or Medical Assessor, as applicable.

(24) Sleeping tablets. Sleeping tablets dull the senses, may cause confusion and slow reaction times. The duration of effect may vary from individual to individual and may be unduly prolonged. Air traffic controllers using sleeping tablets should consult an AME, AeMC, or Medical Assessor, as applicable.

(25) Melatonin. Melatonin is a hormone that is involved with the regulation of the circadian rhythm. In some countries it is a prescription medicine, whereas in most other countries it is regarded as a 'dietary supplement' and can be bought without any prescription. The results from the efficiency of melatonin in treatment of jet lag or sleep disorders have been contradictory. Air traffic controllers using melatonin should consult an AME, AeMC, or Medical Assessor, as applicable.

(26) Coffee and other caffeinated drinks may be acceptable, but excessive coffee drinking may have harmful effects, including disturbance of the heart's rhythm. Other stimulants including caffeine pills, amphetamines, etc. (often known as 'pep' pills) used to maintain wakefulness or suppress appetite can be habit forming. Susceptibility to different stimulants varies from one individual to another, and all may cause dangerous overconfidence. Overdosage causes headaches, dizziness and mental disturbance. These other stimulants should not be used.

(27) Anaesthetics. Following local, general, dental and other anaesthetics, a period of time should elapse before returning to exercising the privileges of the licence. The period will vary considerably from individual to individual, but an air traffic controller should not exercise the privileges of the licence for at least 12 hours after a local anaesthetic, and for at least 48 hours after a general, spinal or epidural anaesthetic.

(e) Many preparations on the market nowadays contain a combination of medicines. It is, therefore, essential that if there is any new medication or dosage, however slight, the effect should be observed by the air traffic controller whilst not exercising the privileges of the licence. It should be noted that medication which would not normally affect air traffic controller performance may do so in individuals who are 'oversensitive' to a particular preparation. Individuals are, therefore, advised not to take any medicines before or whilst exercising the privileges of their licence unless they are completely

familiar with their effects on their own bodies. In cases of doubt, air traffic controllers should consult an AME, AeMC, or Medical Assessor, as applicable.

(f) Other treatments

Alternative or complementary medicine, such as acupuncture, homeopathy, hypnotherapy and several other disciplines, is developing and gaining greater credibility. Such treatments are more acceptable in some States than others. There is a need to ensure that 'other treatments', as well as the underlying condition, are declared and considered by the AME, AeMC, or Medical Assessor, as applicable, for assessing fitness.

AMC1 MED.A.035 Application for a medical certificate

Except for initial applicants, when applicants do not present the most recent medical certificate to the AeMC or AME prior to the relevant examinations, the AeMC or AME should not issue the medical certificate unless relevant information is received from the Kuwait DGCA.

AMC1 MED.E.006 Limitations to medical certificates

(a) An AeMC or AME may refer the decision on fitness of an applicant to the Kuwait DGCA in borderline cases or where fitness is in doubt.

(b) In cases where a fit assessment may only be considered with a limitation, the AeMC, AME or the Kuwait DGCA should evaluate the medical condition of the applicant with appropriate personnel from the air navigation service provider and other experts, if necessary.

(c) Entry of limitations

(1) Limitations TML, VDL, VML, VNL, CCL, HAL, RXO may be imposed by an AME or an AeMC.

(2) Limitations VXL and VXN should be imposed with advice of the air navigation service provider.

(3) Limitations SIC and SSL should only be imposed by the Kuwait DGCA

(d) Removal of limitations

All limitations should only be removed by the DGCA

AMC2 MED.E.006 Limitations to medical certificates

LIMITATION CODES

(a) The following abbreviations for limitations should be used on the medical certificate as applicable:

Code	Limitation
TML	Restriction of the period of validity of the medical certificate
VDL	Wear correction for defective distant vision and carry spare set of spectacles
VXL	Correction for defective distant vision depending on the working environment

Code	Limitation
VML	Wear correction for defective distant, intermediate and near vision and carry spare set of spectacles
VNL	Have correction available for defective near vision and carry spare set of spectacles
VXN	Correction for defective near vision; correction for defective distant vision depending on the working environment
RXO	Specialist ophthalmological examinations
CCL	Correction by means of contact lenses
HAL	Valid only when hearing aids are worn
SIC	Specific medical examination(s)
SSL	Special restrictions as specified

(b) The abbreviations for the limitation codes should be explained to the holder of a medical certificate as follows:

(1) TML — Time limitation

The period of validity of the medical certificate is limited to the duration as shown on the medical certificate. This period of validity commences on the date of the aero-medical examination. Any period of validity remaining on the previous medical certificate is no longer valid. The holder of a medical certificate should present him/herself for reassessment or examination when advised and should follow any medical recommendations.

(2) VDL — Wear corrective lenses and carry a spare set of spectacles

Correction for defective distant vision: whilst exercising the privileges of the licence, the holder of a medical certificate should wear spectacles or contact lenses that correct for defective distant vision as examined and approved by the AeMC or AME. Contact lenses may not be worn until cleared to do so by an AeMC or AME. A spare set of spectacles, approved by the AeMC or AME, should be readily available.

(3) VXL — Correction for defective distant vision depending on the working environment

Correction for defective distant vision does not have to be worn if the air traffic controller's visual working environment is in the area of up to 100 cm. Applicants who do not meet the uncorrected distant visual acuity requirement but meet the visual acuity requirement for intermediate and near vision without correction and whose visual working environment is only the intermediate and near vision area (up to 100 cm) may work without corrective lenses.

(28) VML — Wear multifocal spectacles and carry a spare set of spectacles

Correction for defective distant, intermediate and near vision: whilst exercising the privileges of the licence, the holder of a medical certificate should wear spectacles that correct for defective distant, intermediate and near vision as examined and

approved by the AeMC or AME. Contact lenses or full-frame spectacles, when either correct for near vision only, may not be worn.

(29) VNL — Have available corrective spectacles and a spare set of spectacles

Correction for defective near vision: whilst exercising the privileges of the licence, the holder of a medical certificate should have readily available spectacles that correct for defective near vision as examined and approved by the AeMC or AME. Contact lenses or full-frame spectacles, when either correct for near vision only, may not be worn.

(30) VXN — Have available corrective spectacles and a spare set of spectacles; correction for defective distant vision depending on the working environment.

Correction for defective distant vision does not have to be worn if the air traffic controller's visual working environment is in the area of up to 100 cm. Applicants who do not meet the uncorrected distant and uncorrected near visual acuity requirements, but meet the visual acuity requirement for intermediate vision without correction and whose visual working environment is only the intermediate and near vision area (up to 100 cm) should have readily available spectacles and a spare set that correct for defective near vision as examined and approved by the AeMC or AME. Contact lenses or full-frame spectacles, when either correct for near vision only, may not be worn.

(31) CCL — Wear contact lenses that correct for defective vision

Correction for defective distant vision: whilst exercising the privileges of the licence, the holder of a medical certificate should wear contact lenses that correct for defective distant vision, as examined and approved by the AeMC or AME. A spare set of similarly correcting spectacles shall be readily available for immediate use whilst exercising the privileges of the licence.

(32) RXO — Specialist ophthalmological examination(s)

Specialist ophthalmological examination(s), other than the examinations stipulated in this Part, are required for a significant reason.

(33) HAL — Hearing aid(s)

Whilst exercising the privileges of the licence, the holder of the medical certificate should use hearing aid(s) that compensate(s) for defective hearing as examined and approved by the AeMC or AME. A spare set of batteries should be available.

(34) SIC — Specific medical examination(s)

This limitation requires the AeMC or AME to contact the Kuwait DGCA before embarking upon renewal or revalidation aero-medical assessment. It is likely to concern a medical history of which the AME should be aware prior to undertaking the aero-medical assessment.

(35) SSL — Special restrictions as specified

This limitation may be considered when an individually specified limitation, not defined in this paragraph, is appropriate to mitigate an increased level of risk to the safe exercise of the privileges of the licence. The description of the SSL should be entered on the medical certificate or in a separate document to be carried with the medical certificate.

AMC1 MED.E.010 Cardiovascular system

(a) Electrocardiography

(1) An exercise electrocardiogram (ECG) when required as part of a cardiovascular assessment should be symptom-limited and completed to a minimum of Bruce Stage IV or equivalent.

(2) Reporting of resting and exercise ECGs should be carried out by the AME or an appropriate specialist.

(b) General

(1) Cardiovascular risk factor assessment

(i) Serum/plasma lipid estimation is case finding and significant abnormalities should require investigation and management under the supervision of the AeMC or AME in consultation with the Kuwait DGCA if necessary.

(ii) An accumulation of risk factors (smoking, family history, lipid abnormalities, hypertension, etc.) should require cardiovascular evaluation by the AeMC or AME in consultation with the Kuwait DGCA if necessary.

(2) Extended cardiovascular assessment

(i) The extended cardiovascular assessment should be undertaken at an AeMC or by a cardiologist.

(ii) The extended cardiovascular assessment should include an exercise ECG or other test that will provide equivalent information.

(c) Peripheral arterial disease

Applicants with peripheral arterial disease, before or after surgery, should undergo satisfactory cardiological evaluation including an exercise ECG and 2D echocardiography. Further tests may be required which should show no evidence of myocardial ischaemia or significant coronary artery stenosis. A fit assessment may be considered provided:

(1) the exercise ECG is satisfactory; and

(2) there is no sign of significant coronary artery disease or evidence of significant atheroma elsewhere, and no functional impairment of the end organ supplied.

(d) Aortic aneurysm

(1) Applicants with an aneurysm of the infra-renal abdominal aorta may be assessed as fit following a satisfactory cardiological evaluation. Regular evaluations by a cardiologist should be carried out.

(2) Applicants may be assessed as fit after surgery for an aneurysm of the thoracic or abdominal aorta if the blood pressure and cardiovascular evaluation are satisfactory. Regular evaluations by a cardiologist should be carried out.

(e) Cardiac valvular abnormalities

(1) Applicants with previously unrecognised cardiac murmurs should require cardiological evaluation. If considered significant, further investigation should include at least 2D Doppler echocardiography.

(2) Applicants with minor cardiac valvular abnormalities may be assessed as fit by the Kuwait DGCA. Applicants with significant abnormality of any of the heart valves should be assessed as unfit.

(3) Aortic valve disease

(i) Applicants with bicuspid aortic valve may be assessed as fit if no other cardiac or aortic abnormality is demonstrated. Regular cardiological follow-up, including 2D Doppler echocardiography, may be required.

(ii) Applicants with mild aortic stenosis may be assessed as fit. Annual cardiological follow-up may be required and should include 2D Doppler echocardiography.

(iii) Applicants with aortic regurgitation may be assessed as fit only if regurgitation is minor and there is no evidence of volume overload. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Cardiological follow-up including 2D Doppler echocardiography may be required.

(4) Mitral valve disease

(i) Applicants with rheumatic mitral stenosis may only be assessed as fit in favourable cases after cardiological evaluation including 2D echocardiography.

(ii) Applicants with uncomplicated minor regurgitation may be assessed as fit. Regular cardiological follow-up including 2D echocardiography may be required.

(iii) Applicants with mitral valve prolapse and mild mitral regurgitation may be assessed as fit.

(iv) Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter should be assessed as unfit.

(f) Valvular surgery

Applicants with cardiac valve replacement/repair should be assessed as unfit. After a satisfactory cardiological evaluation, fit assessment may be considered.

(1) Asymptomatic applicants may be assessed as fit by the Kuwait DGCA six months after valvular surgery subject to:

(i) normal valvular and ventricular function as judged by 2D Doppler echocardiography;

(ii) satisfactory symptom-limited exercise ECG or equivalent;

(iii) demonstrated absence of coronary artery disease unless this has been satisfactorily treated by re-vascularisation;

(iv) no cardioactive medication is required;

(v) annual cardiological follow-up to include an exercise ECG and 2D Doppler echocardiography. Longer periods may be acceptable once a stable condition has been confirmed by cardiological evaluations.

(36) Applicants with implanted mechanical valves may be assessed as fit subject to documented exemplary control of their anti-coagulant therapy. Age factors should form part of the risk assessment.

(g) Thromboembolic disorders

Applicants with arterial or venous thrombosis or pulmonary embolism should be assessed as unfit during the first six months of anticoagulation. A fit assessment, with a limitation if necessary, may be considered by the Kuwait DGCA after six months of stable anticoagulation. Anticoagulation should be considered stable if, within the last six months, at least five international normalised ratio (INR) values are documented, of which at least four are within the INR target range and the haemorrhagic risk is acceptable. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment may be considered after review by the Kuwait DGCA after a period of three months. Applicants with pulmonary embolism should also be evaluated by a cardiologist. Following cessation of anticoagulant therapy, for any indication, applicants should undergo a reassessment by the Kuwait DGCA.

(h) Other cardiac disorders

(1) Applicants with a primary or secondary abnormality of the pericardium, myocardium or endocardium should be assessed as unfit. A fit assessment may be considered following complete resolution and satisfactory cardiological evaluation which may include 2D Doppler echocardiography, exercise ECG, 24-hour ambulatory ECG, and/or myocardial perfusion scan or equivalent test. Coronary angiography may be indicated. Regular cardiological follow-up may be required.

(2) Applicants with a congenital abnormality of the heart should be assessed as unfit. Applicants following surgical correction or with minor abnormalities that are functionally unimportant may be assessed as fit following cardiological assessment. No cardioactive medication is acceptable. Investigations may include 2D Doppler echocardiography, exercise ECG and 24-hour ambulatory ECG. Regular cardiological follow-up may be required.

(i) Syncope

(1) Applicants with a history of recurrent episodes of syncope should be assessed as unfit. A fit assessment may be considered after a sufficient period of time without recurrence provided cardiological evaluation is satisfactory.

(2) A cardiological evaluation should include:

(i) a satisfactory symptom exercise ECG. If the exercise ECG is abnormal, a myocardial perfusion scan or equivalent test should be required;

(ii) a 2D Doppler echocardiogram showing neither significant selective chamber enlargement nor structural or functional abnormality of the heart, valves or myocardium;

(iii) a 24-hour ambulatory ECG recording showing no conduction disturbance, complex or sustained rhythm disturbance or evidence of myocardial ischaemia;

(iv) a tilt test carried out to a standard protocol showing no evidence of vasomotor instability.

(37) Neurological review should be required.

(j) Blood pressure

(1) Anti-hypertensive treatment should be agreed by the Kuwait DGCA. Medication may include:

(i) non-loop diuretic agents;

(ii) Angiotensin Converting Enzyme (ACE) inhibitors;

(iii) angiotensin II receptor blocking agents;

(iv) long-acting slow channel calcium blocking agents;

(v) certain (generally hydrophilic) beta-blocking agents.

(38) Following initiation of medication for the control of blood pressure, applicants should be re-assessed to verify that the treatment is compatible with the safe exercise of the privileges of the licence.

(k) Coronary artery disease

(1) Applicants with chest pain of an uncertain cause should undergo a full investigation before a fit assessment may be considered. Applicants with angina pectoris should be assessed as unfit, whether or not it is abolished by medication.

(2) Applicants with suspected asymptomatic coronary artery disease should undergo a cardiological evaluation including exercise ECG. Further tests (myocardial perfusion scanning, stress echocardiography, coronary angiography or equivalent) may be required, which should show no evidence of myocardial ischaemia or significant coronary artery stenosis.

(3) After an ischaemic cardiac event, including revascularisation, applicants without symptoms should have reduced any vascular risk factors to an appropriate level. Medication, when used to control cardiac symptoms, is not acceptable. All applicants should be on acceptable secondary prevention treatment.

(i) A coronary angiogram obtained around the time of, or during, the ischaemic myocardial event and a complete, detailed clinical report of the ischaemic event and of any operative procedures should be available.

(A) there should be no stenosis more than 50% in any major untreated vessel, in any vein or artery graft or at the site of an angioplasty/stent, except in a vessel subtending a myocardial infarction;

(B) the whole coronary vascular tree should be assessed as satisfactory by a cardiologist, and particular attention should be paid to multiple stenoses and/or multiple revascularisations;

(C) an untreated stenosis greater than 30% in the left main or proximal left anterior descending coronary artery should not be acceptable.

(ii) At least six months from the ischaemic myocardial event, including revascularisation, the following investigations should be completed:

(A) an exercise ECG showing neither evidence of myocardial ischaemia nor rhythm or conduction disturbance;

(B) an echocardiogram or equivalent test showing satisfactory left ventricular function with no important abnormality of wall motion (such

as dyskinesia or akinesia) and a left ventricular ejection fraction of 50% or more;

(C) in cases of angioplasty/stenting, a myocardial perfusion scan or equivalent test, which should show no evidence of reversible myocardial ischaemia. If there is any doubt about myocardial perfusion, in other cases (infarction or bypass grafting), a perfusion scan should also be required;

(D) further investigations, such as a 24-hour ECG, may be necessary to assess the risk of any significant rhythm disturbance.

(iii) Follow-up should be conducted annually (or more frequently, if necessary) to ensure that there is no deterioration of the cardiovascular status. It should include a cardiological evaluation, exercise ECG and cardiovascular risk assessment. Additional investigations may be required.

(iv) After coronary artery vein bypass grafting, a myocardial perfusion scan or equivalent test should be performed on clinical indication, and in all cases within five years from the procedure.

(v) In all cases, coronary angiography, or an equivalent test, should be considered at any time if symptoms, signs or non-invasive tests indicate myocardial ischaemia.

(vi) Applicants may be assessed as fit after successful completion of the three-month or subsequent review.

(l) Rhythm and conduction disturbances

(1) Applicants with any significant rhythm or conduction disturbance may be assessed as fit after cardiological evaluation and with appropriate follow-up. Such evaluation should include:

(i) exercise ECG which should show no significant abnormality of rhythm or conduction, and no evidence of myocardial ischaemia. Withdrawal of cardioactive medication prior to the test should be required;

(ii) 24-hour ambulatory ECG which should demonstrate no significant rhythm or conduction disturbance;

(iii) 2D Doppler echocardiogram which should show no significant selective chamber enlargement or significant structural or functional abnormality, and a left ventricular ejection fraction of at least 50%.

Further evaluation may include:

(iv) 24-hour ECG recording repeated as necessary;

(v) electrophysiological study;

(vi) myocardial perfusion imaging or equivalent test;

(vii) cardiac magnetic resonance imaging (MRI) or equivalent test;

(viii) coronary angiogram or equivalent test.

(39) Applicants with supraventricular or ventricular ectopic complexes on a resting ECG may require no further evaluation, provided the frequency can be shown to be no greater than one per minute, for example on an extended ECG strip.

Applicants with asymptomatic isolated uniform ventricular ectopic complexes may be assessed as fit, but frequent or complex forms require full cardiological evaluation.

(40) Where anticoagulation is needed for a rhythm disturbance, a fit assessment may be considered if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last six months, at least five INR values are documented, of which at least four are within the INR target range. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an appropriate limitation may be considered after review by the Kuwait DGCA after a period of three months.

(41) Ablation

(i) Applicants who have undergone ablation therapy should be assessed as unfit for a minimum period of two months.

(ii) A fit assessment may be considered following successful catheter ablation provided an electrophysiological study (EPS) demonstrates satisfactory control has been achieved.

(iii) Where EPS is not performed, longer periods of unfitness and cardiological follow-up should be considered.

(iv) Follow-up should include a cardiological review.

(42) Supraventricular arrhythmias

Applicants with significant disturbance of supraventricular rhythm, including sinoatrial dysfunction, whether intermittent or established, should be assessed as unfit. A fit assessment may be considered if cardiological evaluation is satisfactory.

(i) For initial applicants with atrial fibrillation/flutter, a fit assessment should be limited to those with a single episode of arrhythmia which is considered to be unlikely to recur.

(ii) For revalidation, applicants may be assessed as fit if cardiological evaluation is satisfactory and the stroke risk is sufficiently low. A fit assessment may be considered after a period of stable anticoagulation as prophylaxis, after review by the Kuwait DGCA. Anticoagulation should be considered stable if, within the last six months, at least five INR values are documented, of which at least four are within the INR target range. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment may be considered after review by the Kuwait DGCA after a period of three months.

(iii) Applicants with asymptomatic sinus pauses up to 2.5 seconds on a resting ECG may be assessed as fit if exercise ECG, 2D echocardiography and 24-hour ambulatory ECG are satisfactory.

(iv) Applicants with symptomatic sino-atrial disease should be assessed as unfit.

(43) Mobitz type 2 atrio-ventricular block

Applicants with Mobitz type 2 AV block may be assessed as fit after a full cardiological evaluation confirms the absence of distal conducting tissue disease.

(44) Complete right bundle branch block

Applicants with complete right bundle branch block should require cardiological evaluation on first presentation.

(45) Complete left bundle branch block

A fit assessment may be considered as follows:

(i) Initial applicants may be assessed as fit after full cardiological evaluation showing no pathology. Depending on the clinical situation, a period of stability may be required.

(ii) Applicants for revalidation or renewal of a medical certificate with a de-novo left bundle branch block may be assessed as fit after cardiological evaluation showing no pathology. A period of stability may be required.

(iii) A cardiological evaluation should be required after 12 months in all cases.

(46) Ventricular pre-excitation

Applicants with pre-excitation may be assessed as fit if they are asymptomatic, and an electrophysiological study, including an adequate drug-induced autonomic stimulation protocol, reveals no inducible re-entry tachycardia and the existence of multiple pathways is excluded. Cardiological follow-up should be required including a 24-hour ambulatory ECG recording showing no tendency to symptomatic or asymptomatic tachy-arrhythmia.

(47) Pacemaker

Applicants with a subendocardial pacemaker may be assessed as fit three months after insertion provided:

(i) there is no other disqualifying condition;

(ii) bipolar lead systems programmed in bipolar mode without automatic mode change have been used;

(iii) that the applicant is not pacemaker dependent;

(iv) regular cardiological follow-up should include a symptom-limited exercise ECG that shows no abnormality or evidence of myocardial ischaemia.

(48) QT prolongation

Applicants with asymptomatic QT-prolongation may be assessed as fit subject to a satisfactory cardiological evaluation.

(49) Brugada pattern on electrocardiography

Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitations as appropriate, subject to satisfactory cardiological evaluation.

GM1 MED.E.010 Cardiovascular system

MITRAL VALVE DISEASE

(a) Minor regurgitation should have evidence of no thickened leaflets or flail chordae and left atrial internal diameter of less than or equal to 4.0 cm.

(b) The following may indicate severe regurgitation:

(1) LV internal diameter (diastole) > 6.0 cm; or

(2) LV internal diameter (systole) > 4.1 cm; or

(3) Left atrial internal diameter > 4.5 cm.

(c) Doppler indices, such as width of jet, backwards extension and whether there is flow reversal in the pulmonary veins may be helpful in assessing severity of regurgitation.

GM2 MED.E.010 Cardiovascular system

VENTRICULAR PRE-EXCITATION

(a) Asymptomatic applicants with pre-excitation may be assessed as fit at revalidation if they meet the following criteria:

(1) no inducible re-entry;

(2) refractory period > 300 ms;

(3) no induced atrial fibrillation.

(b) There should be no evidence of multiple accessory pathways.

GM3 MED.E.010 Cardiovascular system

(a) COMPLETE LEFT BUNDLE BRANCH BLOCK

(b) Left bundle branch block is more commonly associated with coronary artery disease and, thus, requires more in-depth investigation, which may be invasive.

GM4 MED.E.010 Cardiovascular system

PACEMAKER

(a) Scintigraphy may be helpful in the presence of conduction disturbance/paced complexes in the resting ECG.

(b) Experience has shown that any failures of pacemakers are most likely to occur in the first three months after being fitted. Therefore, a fit assessment should not be considered before this period has elapsed.

(c) It is known that certain operational equipment may interfere with the performance of the pacemaker. The type of pacemaker used, therefore, should have been tested to ensure it does not suffer from interference in the operational environment. Supporting data and a performance statement to this effect should be available from the supplier.

GM5 MED.E.010 Cardiovascular system

(a) ANTICOAGULATION

(b) Applicants and licence holders taking anticoagulant medication which requires monitoring with INR testing, should measure their INR on a ‘near patient’ testing system within 12 hours prior to starting a shift pattern and then at least every three days during the shift pattern. The privileges of the licence should only be exercised if the INR is

within the target range. The INR result should be recorded and the results should be reviewed at each aero-medical assessment.

AMC1 MED.E.015 Respiratory system

(a) Examination

(4) Spirometric examination is required for initial examination. An FEV1/FVC ratio less than 70% should require evaluation by a specialist in respiratory disease before a fit assessment can be considered.

(5) Posterior/anterior chest radiography may be required at initial, revalidation or renewal examinations when indicated on clinical or epidemiological grounds.

(b) Chronic obstructive airways disease

Applicants with chronic obstructive airways disease should be assessed as unfit. Applicants with only minor impairment of their pulmonary function may be assessed as fit after specialist respiratory evaluation. Applicants with pulmonary emphysema may be assessed as fit following specialist evaluation showing that the condition is stable and not causing significant symptoms.

(c) Asthma

Applicants with asthma requiring medication or experiencing recurrent attacks of asthma may be assessed as fit if the asthma is considered stable with satisfactory pulmonary function tests and medication is compatible with the safe execution of the privileges of the licence. Use of low dose systemic steroids may be acceptable.

(d) Inflammatory disease

(1) For applicants with active inflammatory disease of the respiratory system, a fit assessment may be considered when the condition has resolved without sequelae and no medication is required.

(50) Applicants with chronic inflammatory diseases may be assessed as fit following specialist evaluation showing mild disease with acceptable pulmonary function test and medication compatible with the safe execution of the privileges of the licence.

(e) Sarcoidosis

(1) Applicants with active sarcoidosis should be assessed as unfit. Specialist evaluation should be undertaken with respect to the possibility of systemic, particularly cardiac, involvement. A fit assessment may be considered if no medication is required, and the disease is limited to hilar lymphadenopathy and inactive. Use of low dose systemic steroids may be acceptable.

(2) Applicants with cardiac or neurological sarcoid should be assessed as unfit.

(f) Pneumothorax

Applicants with a spontaneous pneumothorax should be assessed as unfit. A fit assessment may be considered:

(1) six weeks after the event provided full recovery from a single event has been confirmed in a full respiratory evaluation including a CT scan or equivalent;

(2) following surgical intervention in the case of a recurrent pneumothorax provided there is satisfactory recovery.

(g) Thoracic surgery

(1) Applicants requiring thoracic surgery should be assessed as unfit until such time as the effects of the operation are no longer likely to interfere with the safe exercise of the privileges of the licence.

(2) A fit assessment may be considered after satisfactory recovery and full respiratory evaluation including a CT scan or equivalent. The underlying pathology which necessitated the surgery should be considered in the aero-medical assessment.

(h) Sleep apnoea syndrome/sleep disorder

(1) Applicants with unsatisfactorily treated sleep apnoea syndrome and suffering from excessive daytime sleepiness should be assessed as unfit.

(2) A fit assessment may be considered subject to the extent of symptoms, including vigilance, and satisfactory treatment. ATCO operational experience, sleep apnoea syndrome/sleep disorder education and work place considerations are essential components of the aero-medical assessment.

AMC1 MED.E.020 Digestive system

(a) Oesophageal varices

Applicants with oesophageal varices should be assessed as unfit.

(b) Pancreatitis

(1) Applicants with pancreatitis should be assessed as unfit. A fit assessment may be considered if the cause (e.g. gallstone, other obstruction, medication) is removed.

(2) Alcohol may be a cause of dyspepsia and pancreatitis. If considered appropriate, a full evaluation of its use or misuse should be undertaken.

(c) Gallstones

(1) Applicants with a single large gallstone may be assessed as fit after evaluation.

(2) Applicants with multiple gallstones may be assessed as fit while awaiting treatment provided the symptoms are unlikely to interfere with the safe exercise of the privileges of the licence.

(d) Inflammatory bowel disease

Applicants with an established diagnosis or history of chronic inflammatory bowel disease may be assessed as fit if the disease is in established stable remission, and only minimal, if any, medication is being taken. Regular follow-up should be required.

(e) Dyspepsia

Applicants with recurrent dyspepsia requiring medication should be investigated by internal examination including radiologic or endoscopic examination. Laboratory testing should include haemoglobin assessment and faecal examination. Any demonstrated ulceration or significant inflammation requires evidence of recovery before a fit assessment may be considered.

(f) Digestive tract and abdominal surgery

Applicants who have undergone a surgical operation on the digestive tract or its adnexa, including a total or partial excision or a diversion of any of these organs, should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic and the risk of secondary complication or recurrence is minimal.

AMC1 MED.E.025 Metabolic , Nutritional and endocrine system

(a) Metabolic, nutritional or endocrine dysfunction

Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit if the condition is asymptomatic, clinically compensated and stable with or without replacement therapy, and regularly reviewed by an appropriate specialist.

(b) Obesity

(1) Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken.

(2) Functional testing in the working environment may be necessary before a fit assessment may be considered.

(c) Thyroid dysfunction

Applicants with hyperthyroidism or hypothyroidism should attain a stable euthyroid state before a fit assessment may be considered.

(d) Abnormal glucose metabolism

Glycosuria and abnormal blood glucose levels require investigation. A fit assessment may be considered if normal glucose tolerance is demonstrated (low renal threshold) or impaired glucose tolerance without diabetic pathology is fully controlled by diet and regularly reviewed.

(e) Diabetes mellitus

(1) The following medication, alone and in combination, may be acceptable for control of type 2 diabetes:

(2) alpha-glucosidase inhibitors;

(i) medication that acts on the incretin pathway;

(ii) biguanides.

(3) A fit assessment may be considered after evaluation of the operational environment, including means of glucose monitoring/management whilst performing rated duties, and with demonstrated exemplary glycaemic control.

(4) Annual follow-up by a specialist should be required including demonstration of absence of complications, good glycaemic control demonstrated by six-monthly HbA1c measurements, and a normal exercise tolerance test.

AMC1 MED.E.030 Haematology

(a) Anaemia

(1) Anaemia demonstrated by a reduced haemoglobin level should require investigation. A fit assessment may be considered in cases where the primary cause has been treated (e.g. iron or B12 deficiency) and the haemoglobin or haematocrit has stabilised at a satisfactory level. The recommended range of the haemoglobin level is 11–17 g/dl.

(2) Anaemia which is unamenable to treatment should be disqualifying.

(b) Haemoglobinopathy

Applicants with a haemoglobinopathy should be assessed as unfit. A fit assessment may be considered where minor thalassaemia, sickle cell disease or other haemoglobinopathy is diagnosed without a history of crises and where full functional capability is demonstrated.

(c) Coagulation disorders

(1) Significant coagulation disorders require investigation. A fit assessment may be considered if there is no history of significant bleeding or clotting episodes and the haematological data indicate that it is safe to do so.

(2) If anticoagulant therapy is prescribed, AMC1 ATCO.MED.B.010 (g) should be followed.

(d) Disorders of the lymphatic system

Lymphatic enlargement requires investigation. A fit assessment may be considered in cases of an acute infectious process which is fully recovered, or Hodgkin's lymphoma, or other lymphoid malignancy which has been treated and is in full remission, or that requires minimal or no treatment.

(e) Leukaemia

(1) Applicants with acute leukaemia should be assessed as unfit. Once in established remission, applicants may be assessed as fit.

(2) Applicants with chronic leukaemia should be assessed as unfit. A fit assessment may be considered after remission and a period of demonstrated stability.

(3) Applicants with a history of leukaemia should have no history of central nervous system involvement and no continuing side effects from treatment which are likely to interfere with the safe exercise of the privileges of the licence. Haemoglobin and platelet levels should be satisfactory.

(4) Regular follow-up is required in all cases of leukaemia.

(f) Splenomegaly

Splenomegaly requires investigation. A fit assessment may be considered if the enlargement is minimal, stable and no associated pathology is demonstrated, or if the enlargement is minimal and associated with another acceptable condition.

GM1 MED.E.030 Haematology

HODGKIN'S LYMPHOMA

Due to potential side effects of specific chemotherapeutic agents, the precise regime utilised should be taken into account.

GM2 MED.E.030 Haematology

CHRONIC LEUKAEMIA

A fit assessment may be considered if the chronic leukaemia has been diagnosed as:

(a) lymphatic at stages 0, I, and possibly II without anaemia and minimal treatment; or

(b) stable 'hairy cell' leukaemia with normal haemoglobin and platelets.

GM3 MED.E.030 Haematology

SPLENOMEGALY

(a) Splenomegaly should not preclude a fit assessment, but should be assessed on an individual basis.

(b) Associated pathology of splenomegaly is e.g. treated chronic malaria.

(c) An acceptable condition associated with splenomegaly is e.g. Hodgkin's lymphoma in remission.

AMC1 MED.E.035 Urinary system

(a) Abnormal urinalysis

Any abnormal finding on urinalysis requires investigation. This investigation should include proteinuria, haematuria and glycosuria.

(b) Renal disease

(1) Applicants presenting with any signs of renal disease should be assessed as unfit. A fit assessment may be considered if blood pressure is satisfactory and renal function is acceptable.

(2) Applicants requiring dialysis should be assessed as unfit.

(c) Urinary calculi

(1) Applicants with an asymptomatic calculus or a history of renal colic require investigation. A fit assessment may be considered after successful treatment for a calculus and with appropriate follow-up.

(2) Residual calculi should be disqualifying unless they are in a location where they are unlikely to move and give rise to symptoms.

(d) Renal and urological surgery

(1) Applicants who have undergone a major surgical operation on the genitourinary system or its adnexa involving a total or partial excision or a diversion of any of its organs should be assessed as unfit until recovery is complete, the applicant is asymptomatic and the risk of secondary complications is minimal.

(2) Applicants with compensated nephrectomy without hypertension or uraemia may be assessed as fit.

(3) Applicants who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and tolerated with only minimal immuno-suppressive therapy after at least 12 months.

(4) Applicants who have undergone total cystectomy may be considered for a fit assessment if there is satisfactory urinary function, no infection and no recurrence of primary pathology.

AMC1 MED.E.040 Infectious diseases

(a) Infectious disease — General

In cases of infectious disease, consideration should be given to a history of, or clinical signs indicating, underlying impairment of the immune system.

(b) Tuberculosis

(1) Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy.

(2) Applicants with quiescent or healed lesions may be assessed as fit. Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.

(c) Syphilis

Applicants with acute syphilis should be assessed as unfit. A fit assessment may be considered in the case of those fully treated and recovered from the primary and secondary stages.

(d) Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)

(e) Applicants with other chronic infections may be assessed as fit provided the infections are not likely to interfere with the safe exercise of the privileges of the licence.

AMC1 MED.E.045 Obstetrics and gynaecology

(a) Gynaecological surgery

Applicants who have undergone a major gynaecological operation should be assessed as unfit until recovery is complete, the applicant is asymptomatic and the risk of secondary complications or recurrence is minimal.

(b) Pregnancy

(1) A pregnant licence holder may be assessed as fit during the first 34 weeks of gestation provided obstetric evaluation continuously indicates a normal pregnancy.

(2) The AeMC or AME or the Kuwait DGCA should provide written advice to the applicant and the supervising physician regarding potentially significant complications of pregnancy which may negatively influence the safe exercise of the privileges of the licence.

AMC1 MED.E.050 Musculoskeletal system

(a) Applicants with any significant sequelae from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery require full evaluation prior to a fit assessment.

(b) Abnormal physique, including obesity, or muscular weakness may require aero-medical assessment and particular attention should be paid to an aero-medical assessment in the working environment.

(c) Locomotor dysfunction, amputations, malformations, loss of function and progressive osteoarthritic disorders should be assessed on an individual basis in conjunction with the appropriate operational expert with a knowledge of the complexity of the tasks of the applicant.

(d) Applicants with inflammatory, infiltrative or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission and the medication is acceptable.

AMC1 MED.E.055 Psychiatry

(a) Disorders due to alcohol or other substance use

(1) A fit assessment may be considered after successful treatment, a period of documented sobriety or freedom from substance use, and review by a psychiatric specialist. The Kuwait DGCA, with the advice of the psychiatric specialist, should determine the duration of the period to be observed before a medical certificate can be issued.

(2) Depending on the individual case, treatment may include in-patient treatment of some weeks.

(3) Continuous follow-up, including blood testing and peer reports, may be required indefinitely.

(b) Mood disorder

Applicants with an established mood disorder should be assessed as unfit. After full recovery and after full consideration of an individual case, a fit assessment may be considered depending on the characteristics and gravity of the mood disorder. If stability on maintenance psychotropic medication is confirmed, a fit assessment with an appropriate limitation may be considered. If the dosage of the medication is changed, a further period of unfit assessment should be required. Regular specialist supervision should be required.

(c) Psychotic disorder

Applicants with a history, or the occurrence, of a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and the risk of recurrence is minimal.

(d) Deliberate self-harm

Applicants who have carried out a single self-destructive action or repeated acts of deliberate self-harm should be assessed as unfit. A fit assessment may be considered after full consideration of an individual case which may require psychiatric or psychological evaluation. Neuropsychological evaluation may also be required.

AMC1 MED.E.60 Psychology

(a) If a psychological evaluation is indicated, it should be carried out by a psychologist taking into account the ATC environment and the associated risks.

(b) Where there is established evidence that an applicant may have a psychological disorder, the applicant should be referred for psychological opinion and advice.

(c) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or competence assessments, behaviour or knowledge relevant to the safe exercise of the privileges of the licence.

(d) The psychological evaluation may include a collection of biographical data, the administration of aptitude, as well as personality tests and psychological interview.

(e) The psychologist should submit a written report to the AME, AeMC or Kuwait DGCA as appropriate, detailing his/her opinion and recommendation.

AMC1 MED.E.65 Neurology

(a) Electroencephalography (EEG)

(1) EEG should be carried out when indicated by the applicant's history or on clinical grounds.

(2) Epileptiform paroxysmal EEG abnormalities and focal slow waves should be disqualifying. A fit assessment may be considered after further evaluation.

(b) Epilepsy

(1) Applicants who have experienced one or more convulsive episodes after the age of five should be assessed as unfit.

(2) A fit assessment may be considered if:

(i) the applicant is seizure free and off medication for a period of at least 10 years;

(ii) full neurological evaluation shows that a seizure was caused by a specific non-recurrent cause, such as trauma or toxin.

(3) Applicants who have experienced an episode of benign Rolandic seizure may be assessed as fit provided the seizure has been clearly diagnosed including a properly documented history and typical EEG result and the applicant has been free of symptoms and off treatment for at least 10 years.

(c) Neurological disease

Applicants with any stationary or progressive disease of the nervous system which has caused or is likely to cause a significant disability should be assessed as unfit. A fit assessment may be considered after full neurological evaluation in cases of minor functional losses associated with stationary disease.

(d) Disturbance of consciousness

Applicants with a history of one or more episodes of disturbed consciousness may be assessed as fit if the condition can be satisfactorily explained by a non-recurrent cause. A full neurological evaluation is required.

(e) Head injury

Applicants with a head injury which was severe enough to cause loss of consciousness or is associated with penetrating brain injury should be evaluated by a consultant neurologist. A fit assessment may be considered if there has been a full recovery and the risk of epilepsy is sufficiently low. Behavioural and cognitive aspects should be taken into account.

AMC1 MED.E.070 Visual system

(a) Eye examination

(1) At each aero-medical revalidation examination, the visual fitness should be assessed and the eyes should be examined with regard to possible pathology.

(2) All abnormal and doubtful cases should be referred to an ophthalmologist. Conditions which indicate ophthalmological examination include but are not limited to a substantial decrease in the uncorrected visual acuity, any decrease in best corrected visual acuity and/or the occurrence of eye disease, eye injury or eye surgery.

(3) Where ophthalmological examinations are required for any significant reason, this should be imposed as a limitation on the medical certificate.

(4) The effect of multiple eye conditions should be evaluated by an ophthalmologist with regard to possible cumulative effects. Functional testing in the working environment may be necessary to consider a fit assessment.

(5) Visual acuity should be tested using Snellen charts, or equivalent, under appropriate illumination. Where clinical evidence suggests that Snellen may not be appropriate, Landolt 'C' may be used.

(b) Comprehensive eye examination

A comprehensive eye examination by an eye specialist is required at the initial examination. All abnormal and doubtful cases should be referred to an ophthalmologist. The examination should include:

(1) history;

(2) visual acuities — near, intermediate and distant vision; uncorrected and with best optical correction if needed;

(3) objective refraction — hyperopic initial applicants with a hyperopia of more than +2 dioptres and under the age of 25 in cycloplegia;

(4) ocular motility and binocular vision;

(5) colour vision;

(6) visual fields;

(7) tonometry(if indicated) ;

(8) examination of the external eye, anatomy, media (slit lamp) and fundoscopy (if Indicated);

(9) assessment of contrast and glare sensitivity (if indicated and available).

(c) Routine eye examination

At each revalidation or renewal examination, the visual fitness should be assessed and the eyes should be examined with regard to possible pathology. All abnormal and doubtful cases should be referred to an ophthalmologist. This routine eye examination should include:

(1) history;

(2) visual acuities — near, intermediate and distant vision; uncorrected and with best optical correction if needed;

(3) morphology by ophthalmoscopy;

(4) further examination on clinical indication.

(d) Refractive error

(1) Applicants with a refractive error between +5.0/-6.0 dioptres may be assessed as fit provided optimal correction has been considered and no significant pathology is demonstrated. If the refractive error exceeds +3.0/-3.0 dioptres, a four-yearly follow-up by an eye specialist should be required.

(2) Applicants with:

(i) a refractive error exceeding -6 dioptres;

(ii) an astigmatic component exceeding 3 dioptres; or

(iii) anisometropia exceeding 3 dioptres;

may be considered for a fit assessment if:

(A) no significant pathology can be demonstrated;

(B) optimal correction has been considered;

(C) visual acuity is at least 6/6 (1.0) in each eye separately with normal visual fields while wearing the optimal spectacle correction;

(D) two-yearly follow-up is undertaken by an eye specialist.

(3) Applicants with hypermetropia exceeding +5.0 dioptres may be assessed as fit subject to a satisfactory ophthalmological evaluation provided there are adequate fusional reserves, normal intraocular pressures and anterior angles and no significant pathology has been demonstrated. Corrected visual acuity in each eye shall be 6/6 or better.

(4) Applicants with a large refractive error shall use contact lenses or high-index spectacle lenses.

(e) Convergence

Applicants with convergence outside the normal range may be assessed as fit provided it does not interfere with near vision (30–50 cm) or intermediate vision (100 cm) with or without correction.

(f) Substandard vision

(1) Applicants with reduced central vision in one eye may be assessed as fit for a revalidation or renewal of a medical certificate if the binocular visual field is normal and the underlying pathology is acceptable according to

ophthalmological evaluation. Testing should include functional testing in the appropriate working environment.

(2) Applicants with acquired substandard vision in one eye (monocularity, functional monocular vision including eye muscle imbalance) may be assessed as fit for revalidation or renewal if the ophthalmological examination confirms that:

(i) the better eye achieves distant visual acuity of 1.0 (6/6), corrected or uncorrected;

(ii) the better eye achieves intermediate and near visual acuity of 0.7 (6/9), corrected or uncorrected;

(iii) there is no significant ocular pathology;

(iv) a functional test in the working environment is satisfactory; and

(v) in the case of acute loss of vision in one eye, a period of adaptation time has passed from the known point of visual loss, during which the applicant is assessed as unfit.

(3) An applicant with a monocular visual field defect may be assessed as fit if the binocular visual fields are normal.

(g) Keratoconus

Applicants with keratoconus may be considered for a fit assessment if the visual requirements are met with the use of corrective lenses and periodic review is undertaken by an ophthalmologist.

(h) Heterophoria

Applicants with heterophoria (imbalance of the ocular muscles) exceeding when measured with optimal correction, if prescribed:

(1) at six metres:

2.0 prism dioptres in hyperphoria,

10.0 prism dioptres in esophoria,

8.0 prism dioptres in exophoria

and

(2) at 33 centimetres:

1.0 prism dioptre in hyperphoria,

8.0 prism dioptres in esophoria,

12.0 prism dioptres in exophoria

may be assessed as fit provided that orthoptic evaluation demonstrates that the fusional reserves are sufficient to prevent asthenopia and diplopia. The Netherlands Optical Society (TNO) testing or equivalent may be carried out to demonstrate fusion (If indicated).

(i) Eye surgery

(1) After refractive surgery or surgery of the cornea including cross linking, a fit assessment may be considered, provided:

(i) satisfactory stability of refraction has been achieved (less than 0.75 dioptres variation diurnally);

(ii) examination of the eye shows no post-operative complications;

(iii) glare sensitivity is normal;

(iv) mesopic contrast sensitivity is not impaired (if indicated);

(v) evaluation is undertaken by an ophthalmologist.

(2) Cataract surgery

Following intraocular lens surgery, including cataract surgery, a fit assessment may be considered once recovery is complete and the visual requirements are met with or without correction. Intraocular lenses should be monofocal and should not impair colour vision.

(3) Retinal surgery/retinal laser therapy

(i) After successful retinal surgery, applicants may be assessed as fit once the recovery is complete. Annual ophthalmological follow-up may be necessary. Longer periods may be acceptable after two years on recommendation of the ophthalmologist.

(ii) After successful retinal laser therapy, applicants may be assessed as fit provided an ophthalmological evaluation shows stability.

(4) Glaucoma surgery

A fit assessment may be considered six months after successful glaucoma surgery, or earlier if recovery is complete. Six-monthly ophthalmological examinations to follow up secondary complications caused by the glaucoma may be necessary.

(5) Extraocular muscle surgery

A fit assessment may be considered not less than six months after surgery and after a satisfactory ophthalmological evaluation.

(j) Visual correction

Spectacles should permit the licence holder to meet the visual requirements at all distances.

GM1 MED.E.070 Visual system

COMPARISON OF DIFFERENT READING CHARTS (APPROXIMATE FIGURES)

(a) Test distance: 40 cm

Decimal	Nieden	Jäger	Snellen	N	Parinaud
1,0	1	2	1,5	3	2
0,8	2	3	2	4	3
0,7	3	4	2,5		
0,6	4	5	3	5	4
0,5	5	5		6	5
0,4	7	9	4	8	6
0,35	8	10	4,5		8
0,32	9	12	5,5	10	10
0,3	9	12		12	
0,25	9	12		14	
0,2	10	14	7,5	16	14
0,16	11	14	12	20	

(b) Test distance: 80 cm

Decimal	Nieden	Jäger	Snellen	N	Parinaud
1,2	4	5	3	5	4
1,0	5	5		6	5
0,8	7	9	4	8.0	6
0,7	8	10	4,5		8
0,63	9	12	5,5	10	10
0,6	9	12		12	10
0,5	9	12		14	10
0,4	10	14	7,5	16	14
0,32	11	14	12	20	14

AMC1 MED.E.075 Colour vision

(a) Pseudoisochromatic plate testing alone is sufficient (Iihara).

(b) Colour vision may be assessed using means to demonstrate normal trichromacy.

GM1 MED.E.075 Colour vision

The means to demonstrate normal trichromacy may include (if available or indicated):

(a) anomaloscopy (Nagel or equivalent). This test is considered passed if the colour match is trichromatic and the matching range is four scale units or less;

(b) Colour Assessment and Diagnosis (CAD) test (if available or indicated).

AMC1 MED.E.080 Otorhinolaryngology

(a) Examination

(1) An otorhinolaryngological examination includes:

(i) history;

(ii) clinical examination including otoscopy, rhinoscopy and examination of the mouth and throat;

(iii) clinical examination of the vestibular system.

(2) Ear, nose and throat (ENT) specialists involved in the aero-medical assessment of air traffic controllers should have an understanding of the functionality required by air traffic controllers whilst exercising the privileges of their licence(s).

(3) Where a full aero-medical assessment and functional check are needed, due regard should be paid to the operational environment in which the operational functions are undertaken.

(b) Hearing

(1) The follow-up of an applicant with hypoacusis should be decided by the Kuwait DGCA. If at the next annual test there is no indication of further deterioration, the normal frequency of testing may be resumed.

(2) An appropriate prosthetic aid may be a special headset with individual earpiece volume controls. Full functional and environmental assessments should be carried out with the chosen prosthetic equipment in use.

(c) Ear conditions

An applicant with a single dry perforation of non-infectious origin and which does not interfere with the normal function of the ear may be considered for a fit assessment.

(d) Vestibular disturbance

The presence of vestibular disturbance and spontaneous or positional nystagmus requires complete vestibular evaluation by a specialist. Significant abnormal caloric or rotational vestibular responses are disqualifying. At revalidation and renewal aero-medical examinations, abnormal vestibular responses should be assessed in their clinical context.

(e) Speech disorder

Applicants with a speech disorder should be assessed with due regard to the operational environment in which the operational functions are undertaken. Applicants with significant disorder of speech or voice should be assessed as unfit.

GM1 MED.E.080 Otorhinolaryngology

HEARING

(a) Speech discrimination test: discriminating speech against other noise including other sources of verbal communication and ambient noise in the working environment, but not against engine noise.

(b) Functional hearing test: the objective of this test is to evaluate the controller's ability to hear the full range of communications that occur in an operational environment and not just through a headset or speaker.

(c) Prosthetic aid: the functional hearing test to be carried out with the prosthetic aid in use is to ensure that the individual is able to perform the functions of his/her licence and that the equipment is not adversely affected by interference from headsets or other factors.

(d) Pure-tone audiometry: testing at frequencies at or above 4000 Hz will aid the early diagnosis of acoustic neuroma, noise-induced hearing loss (NIH) and other disorders of hearing. Particular attention should be paid in cases where there is a significant difference between thresholds of the left and right ear.

AMC1 MED.E.090 Dermatology

(a) Referral to the Kuwait DGCA should be made if doubt exists about the fitness of an applicant with eczema (exogenous and endogenous), severe psoriasis, chronic infections, drug-induced or bullous eruptions or urticaria.

(b) Systemic effects of radiation or pharmacological treatment for a dermatological condition should be evaluated before a fit assessment may be considered.

(c) An applicant with a skin condition that causes pain, discomfort, irritation or itching may only be assessed as fit if the condition can be controlled and does not interfere with the safe exercise of the privileges of the licence.

(d) In cases where a dermatological condition is associated with a systemic illness, full consideration should be given to the underlying illness before a fit assessment may be considered.

AMC1 MED.E.095 Oncology

(a) Applicants who have been diagnosed with a malignant disease may be assessed as fit provided:

(1) After primary treatment there is no evidence of residual malignant disease likely to interfere with the safe exercise of the privileges of the licence;

(2) Time appropriate to the type of tumour has elapsed since the end of primary treatment;

(3) The risk of incapacitation from a recurrence or metastasis is sufficiently low;

(4) There is no evidence of short- or long-term sequelae from treatment. Special attention should be paid to applicants who have received Anthracycline chemotherapy;

(5) Satisfactory oncology follow-up reports are provided to the Kuwait DGCA.

(b) Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.

(c) Applicants with a benign intracerebral tumour may be assessed as fit after satisfactory specialist and neurological evaluation and the condition does not compromise the safe exercise of the privileges of the licence.

(d) Applicants with pre-malignant conditions may be assessed as fit if treated or excised as necessary and there is a regular follow-up.

Appendix I : Alcohol And Substance Abuse Prevention Policy

CAT.GEN.MPA.170 Psychoactive substances

(a) The operator shall take all reasonable measures to ensure that no person enters or is in an aircraft when under the influence of psychoactive substances to the extent that the safety of the aircraft or its occupants is likely to be endangered.

(b) The operator shall develop and implement a policy on the prevention and detection of misuse of psychoactive substances by flight and cabin crew members and by other safety-sensitive personnel under its direct control, in order to ensure that the safety of the aircraft or its occupants is not endangered.

(c) Without prejudice to the applicable national legislation on data protection concerning testing of individuals, the operator shall develop and implement an objective, transparent and on discriminatory procedure for the prevention and detection of cases of misuse of psychoactive substances by its flight and cabin crew and other safetysensitive personnel.

(d) In case of a confirmed positive test result, the operator shall inform its competent authority and the authority responsible for the personnel concerned, such as a medical assessor of the Kuwait DGCA.

END

Affected Pages from Last Update

#	Page	Proposed Alternative
1.	7	[TABLE] 4 April 2024 NPA 2024-02 Inline with EASA (Aug 2023)
2.	9	GM1 MED.A.020 Decrease in medical fitness
3.	9	MEDICATION — GUIDANCE FOR PILOTS AND CABIN CREW MEMBERS
4.	9	Any medication can cause side effects, some of which may impair the safe performance of flying duties. Equally, symptoms of colds, sore throats, diarrhoea and other abdominal upsets may cause little or no problem whilst on the ground but may distract the pilot or cabin crew member and degrade their performance whilst on duty. The in-flight environment may also increase the severity of symptoms which may only be minor whilst on the ground. Therefore, one issue with medication and flying is the underlying condition and, in addition, the symptoms may be compounded by the side effects of the medication prescribed or bought over the counter for treatment. This guidance material provides some help to pilots and cabin crew in deciding whether expert aero-medical advice by an AME, AeMC or Kuwait DGCA medical assessor is needed.
5.	9	Before taking any medication and acting as a pilot or cabin crew member, the following three basic questions should be satisfactorily answered:
6.	9	Do I feel fit to fly?
7.	9	Do I really need to take medication at all?
8.	9	Have I given this particular medication a personal trial on the ground to ensure that it will not have any adverse effects on my ability to fly?
9.	9	Confirming the absence of adverse effects may well need expert aero-medical advice.
10.	9	The following are some widely used medicines with a description of their compatibility with flying duties:
11.	9	Antibiotics. Antibiotics may have short-term or delayed side effects which can affect pilot or cabin crew performance. More significantly, however, their use usually indicates that an infection is present and, thus, the effects of this infection may mean that a pilot or cabin crew member is not fit to fly and should obtain expert aero-medical advice.
12.	9	Anti-malaria drugs. The decision on the need for anti-malaria drugs depends on the geographical areas to be visited, and the risk that the pilot or cabin crew member has of being exposed to mosquitoes and of developing malaria. An expert medical opinion should be obtained to establish whether anti-malaria drugs are needed and what kind of drugs should be used. Most of the anti-malaria drugs (atovaquone plus proguanil, chloroquine, doxycycline) are compatible with flying duties. However, adverse effects associated with mefloquine include insomnia, strange dreams, mood changes, nausea, diarrhoea and headaches. In addition, mefloquine may cause spatial disorientation and lack of fine coordination and is, therefore, not compatible with flying duties.
13.	10	Antihistamines. Antihistamines can cause drowsiness. They are widely used in ‘cold cures’ and in treatment of hay fever, asthma and allergic rashes. They may be in tablet form or a constituent of nose drops or sprays. In many cases, the condition itself may preclude flying, so that, if treatment is necessary, expert aero-medical advice should be sought so that so-called non-sedative antihistamines, which do not degrade human performance, can be prescribed.
14.	10	Cough medicines. Antitussives often contain codeine, dextromethorfan or pseudo- ephedrine which are not compatible with flying duties. However, mucolytic agents (e.g. carbocysteine) are well-tolerated and are compatible with flying duties.
15.	10	Decongestants. Nasal decongestants with no effect on alertness may be compatible with flying duties. However, as the underlying condition requiring the use of decongestants may be incompatible with flying duties, expert aero-medical advice should be sought. For example, oedema of the mucosal membranes causes difficulties in equalising the pressure in the ears or sinuses.
16.	10	Nasal corticosteroids are commonly used to treat hay fever, and they are compatible with flying duties.
17.	10	Common pain killers and antifebrile drugs. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and paracetamol, commonly used to treat pain, fever or headaches, may be compatible with flying duties. However, the pilot or cabin crew member should give affirmative answers to the three basic questions listed in (b) before using the medication and carrying out flying duties.

#	Page	Proposed Alternative
18.	10	Strong analgesics. The more potent analgesics including codeine are opiate derivatives, and may produce a significant decrement in human performance and, therefore, are not compatible with flying duties.
19.	10	Anti-ulcer medicines. Gastric secretion inhibitors such as H2 antagonists (e.g. ranitidine, cimetidine) or proton pump inhibitors (e.g. omeprazole) may be acceptable after diagnosis of the pathological condition. It is important to seek for the medical diagnosis and not to only treat the dyspeptic symptoms.
20.	10	Anti-diarrhoeal drugs. Loperamide is one of the more common anti-diarrhoeal drugs and is usually safe to take whilst flying. However, the diarrhoea itself often makes the pilot and cabin crew member unfit for flying duties.
21.	10	Hormonal contraceptives and hormone replacement therapy usually have no adverse effects and are compatible with flying duties.
22.	10	Erectile dysfunction medication. This medication may cause disturbances in colour vision and dizziness. There should be at least 6 hours between taking sildenafil and flying duty; and 36 hours between taking vardenafil or tadalafil and flying duty.
23.	11	Smoking cessation. Nicotine replacement therapy may be acceptable. However, other medication affecting the central nervous system (buproprion, varenicline) is not acceptable for pilots.
24.	11	High blood pressure medication. Most anti-hypertensive drugs are compatible with flying duties However, if the level of blood pressure is such that drug therapy is required, the pilot or cabin crew member should be monitored for any side effects before carrying out flying duties. Therefore, consultation with the AME, AeMC, or Kuwait DGCA medical assessor as applicable, is needed.
25.	11	Asthma medication. Asthma has to be clinically stable before a pilot or cabin crew member can return to flying duties. The use of respiratory aeroZols or powders, such as corticosteroids, beta-2-agonists or chromoglycic acid may be compatible with flying duties. However, the use of oral steroids or theophylline derivatives is incompatible with flying duty. Pilots or cabin crew members using medication for asthma should consult the AME, AeMC, ~~GMP, OHMP~~ or medical assessor, as applicable.
26.	11	Tranquillisers and sedatives. The inability to react, due to the use of this group of medicines, has been a contributory cause to fatal aircraft accidents. In addition, the underlying condition for which these medications have been prescribed will almost certainly mean that the mental state of a pilot or cabin crew member is not compatible with flying duties.
27.	11	Sleeping tablets. Sleeping tablets dull the senses, may cause confusion and slow reaction times. The duration of effect may vary from individual to individual and may be unduly prolonged. Expert aero-medical advice should be obtained before using sleeping tablets.
28.	11	Melatonin. Melatonin is a hormone that is involved with the regulation of the circadian rhythm. In some countries it is a prescription medicine, whereas in most other countries it is regarded as a 'dietary supplement' and can be bought without any prescription. The results from the efficiency of melatonin in treatment of jet lag or sleep disorders have been contradictory. Expert aero-medical advice should be obtained.
29.	11	Coffee and other caffeinated drinks may be acceptable, but excessive coffee drinking may have harmful effects, including disturbance of the heart's rhythm. Other stimulants including caffeine pills, amphetamines, etc. (often known as 'pep' pills) used to maintain wakefulness or suppress appetite can be habit forming. Susceptibility to different stimulants varies from one individual to another, and all may cause dangerous overconfidence. Overdosage causes headaches, dizziness and mental disturbance. These other stimulants should not be used.
30.	11	Anaesthetics. Following local, general, dental and other anaesthetics, a period of time should elapse before returning to flying. The period will vary considerably from individual to individual, but a pilot or cabin crew member should not fly for at least 12 hours after a local anaesthetic, and for at least 48 hours after a general, spinal or epidural anaesthetic.
31.	11	Many preparations on the market nowadays contain a combination of medicines. It is, therefore, essential that if there is any new medication or dosage, however slight, the effect should be observed by the pilot or the cabin crew member on the ground prior to flying. It should be noted that medication which would not normally affect pilot or cabin crew performance may do so in individuals who are 'oversensitive' to a particular preparation. Individuals are, therefore, advised not to take any medicines before or during flight unless they are completely familiar with their effects on their own bodies. In cases of doubt, pilots and cabin crew members should consult an AME, AeMC, or Kuwait DGCA medical assessor, as applicable.
32.	12	Other treatments

#	Page	Proposed Alternative
33.	12	Alternative or complementary medicine, such as acupuncture, homeopathy, hypnotherapy and several other disciplines, is developing and gaining greater credibility. Such treatments are more acceptable in some States than others. There is a need to ensure that 'other treatments', as well as the underlying condition, are declared and considered by the AME, AeMC, or Kuwait DGCA medical assessor, as applicable, for assessing fitness.
34.	12	AMC1 MED.A.025 Obligations of the AeMC and AME
35.	12	If the medical examination is carried out by two or more AMEs, only one of them should be responsible for coordinating the results of the examination, evaluating the findings with regard to medical fitness, and signing the report.
36.	12	The applicant should be made aware that the associated medical certificate or cabin crew report may be suspended or revoked if the applicant provides incomplete, inaccurate or false statements on their medical history to the AeMC or AME.
37.	12	In cases where the AeMC or AME is required to assess the fitness of an applicant for a class 2 medical certificate in consultation with the medical assessor of the ~~licensing authority~~DGCA/ASD, they should document the consultation in accordance with the procedure established by the ~~competent authority~~DGCA/ASD.
38.	12	The AeMC or AME should give advice to the applicant on treatment and preventive measures if, during the course of the examination, medical conditions or risk factors are identified which may endanger the medical fitness of the applicant in the future.
39.	12	In case of denial or referral to the licensing authority, the AeMC or AME should inform the applicant in writing regarding the result of the assessment in a form and manner established by the competent authority.
40.	12	GM1 MED.A.025 Obligations of the AeMC or AME
41.	12	.
42.	12	GUIDELINES FOR THE AeMC OR AME CONDUCTING THE MEDICAL EXAMINATIONS AND ASSESSMENTS FOR MEDICAL CERTIFICATION OF PILOTS
43.	12	Before performing the medical examination, the AeMC, or AME should:
44.	12	~~(1)~~ verify the applicant's identity by checking their passport, or other official document containing a photograph of the applicant;
45.	12	~~(2)~~ obtain details of the applicant's flight crew licence from the applicant's licensing authority if they do not have their licence with them;
46.	12	~~(3)~~ except for initial applicants, obtain details of the applicant's most recent medical certificate from the medical assessor of the applicant's licensing authority if they do not have their certificate with them;
47.	12	~~(4)~~ in the case of a specific medical examination(s) (SIC) limitation on the existing medical certificate, obtain details of the specific medical condition and any associated instructions from the medical assessor of the applicant's licensing authority. This could include, for example, a requirement to undergo a specific examination or test;
48.	13	~~(5)~~ except for initial applicants, ascertain, from the previous medical certificate, which routine medical test(s) should be conducted, for example electrocardiography (ECG);
49.	13	~~(6)~~ provide the applicant with the application form for a medical certificate and the instructions for completion and ask the applicant to complete the form but not to sign it yet;
50.	13	~~(7)~~ go through the form with the applicant and give information to help the applicant understand the significance of the entries and ask any questions which might help the applicant to recall important historical medical data;
51.	13	~~(8)~~ verify that the form is complete and legible, ask the applicant to sign and date the form and then sign it as well. If the applicant declines to complete the application form fully, inform the applicant that it may not be possible to issue a medical certificate regardless of the outcome of the clinical examination and assessment.
52.	13	Once all the items in (a) have been addressed, the AeMC or AME should:
53.	13	~~(1)~~ perform the medical examination of the applicant in accordance with the applicable rules;
54.	13	~~(2)~~ arrange for additional specialist medical examinations, such as otorhinolaryngology (ENT) or ophthalmology, to be conducted as applicable and obtain the associated report forms or reports;

#	Page	Proposed Alternative
55.	13	~~(3)~~ complete the medical examination report form in accordance with the associated instructions for completion;
56.	13	~~(4)~~ ensure that all of the report forms are complete, accurate and legible.
57.	13	Once all the actions in (b) have been carried out, the AeMC or AME should review the report forms and:
58.	13	~~(1)~~ if satisfied that the applicant meets the applicable medical requirements as set out in Part-MED, issue a medical certificate for the appropriate class, with limitations if necessary. The applicant should sign the certificate once signed by the AeMC or AME; or
59.	13	~~(2)~~ if the applicant does not meet the applicable medical requirements, or if the fitness of the applicant for the class of medical certificate applied for is in doubt:
60.	13	~~(i)~~ refer the decision on medical fitness to, or consult the decision on medical fitness with, the medical assessor of the licensing authority or AME in compliance with MED.B.001; or
61.	13	~~(ii)~~ deny issuance of a medical certificate, explain the reason(s) for denial to the applicant and inform them of their right of a review according to the procedures of the competent authority.
62.	13	The AeMC or AME should send the documents as required by MED.A.025(b) to the medical assessor of the applicant's licensing authority within 5 days from the date of the medical examination. If a medical certificate has been denied or the decision has been referred, the documents should be sent to the medical assessor of the licensing authority on the same day that the denial or referral decision is reached.
63.	15	A class 1 medical certificate includes the privileges and validities of class 2 and LAPL, SPL, BPL, LSA medical certificates.
64.	15	A class 2 medical certificate includes the privileges and validities of a LAPL, SPL, BPL, LSA medical certificate.
65.	15	When applicants do not present a current or previous medical certificate to the AeMC or AME prior to the relevant examinations, the AeMC or AME should not issue the medical certificate unless relevant information is received from Kuwait DGCA/ASD.
66.	16	[TABLE] valid only as or with qualified co-pilot (for class one only) 17 ORL Valid only with a safety pilot if passengers are carried (class two only)
67.	17	Limitations 5 to ~~16~~ 17 should only be imposed:
68.	19	(16) HAL valid only when hearing aids are worn
69.	19	(17) ORL Valid only with a safety pilot if passengers are carried (class two only) This limitation applies to holders of a class 2 or LAPL medical certificate with a medical condition that may lead to an increased level of risk to flight safety when exercising the privileges of the licence. The safety pilot, if carried, should be made aware of the type(s) of possible incapacity that the pilot whose medical certificate has been issued with this limitation may suffer and should be prepared to take over the aircraft controls during flight
70.	21	Periodic ~~cardiolological~~ cardiological review should be determined by the [Company].
71.	22	Where anticoagulation is needed after valvular surgery, a fit assessment with a multi-pilot limitation may be considered after review by the [Company]. The review should show that the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.
72.	22	Applicant with arterial or venous thrombosis or pulmonary embolism are disqualifying whilst anticoagulation is being used as treatment. After 6 months of stable anticoagulation as prophylaxis, a fit assessment with multi-pilot limitation may be considered after review by the [Company]. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. Pulmonary embolus should require full evaluation. Following cessation of anti-coagulant therapy, for any indication, applicants should require review by the [Company].
73.	23	In the case of a single episode of vasovagal syncope which can be explained and is compatible with flight safety, a fit assessment may be considered.

#	Page	Proposed Alternative
74.	24	Chest pain of uncertain cause should require full investigation. Applicants with angina pectoris should be assessed as unfit, whether or not it is alleviated by medication.
75.	26	For revalidation, applicants may be assessed as fit if cardiological evaluation is satisfactory and the stroke risk is sufficiently low.
76.	27	regular follow-up at least every 12 months, including a pacemaker check; and
77.	27	a multi-pilot limitation OML.
78.	27	Brugada pattern on electrocardiography
79.	27	Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitations as appropriate, subject to satisfactory cardiological evaluation.
80.	27	Note: Where anticoagulation is needed for a rhythm disturbance, a fit assessment with an OML may be considered if the haemorrhagic risk is acceptable and the anticoagulation is stable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range. In cases of anticoagulation medication not requiring INR monitoring, a fit assessment with an OML may be considered after review by the medical assessor of the licensing authority after a stabilisation period of 3 months.
81.	27	GM1 MED.B.010 Cardiovascular system
82.	27	MITRAL VALVE DISEASE
83.	27	Minor regurgitation should have evidence of no thickened leaflets or flail chordae and left atrial internal diameter of less than or equal to 4.0 cm.
84.	27	The following may indicate severe regurgitation:
85.	27	(1) LV internal diameter (diastole) > 6.0 cm; or
86.	27	(2) LV internal diameter (systole) > 4.1 cm; or
87.	27	(3) Left atrial internal diameter > 4.5 cm.
88.	28	Doppler indices, such as width of jet, backwards extension and whether there is flow reversal in the pulmonary veins may be helpful in assessing severity of regurgitation.
89.	28	GM2 MED.B.010 Cardiovascular system
90.	28	VENTRICULAR PRE-EXCITATION
91.	28	Asymptomatic applicants with pre-excitation may be assessed as fit if they meet the following criteria, which may also indicate a satisfactory electrophysiological evaluation:
92.	28	refractory period > 300 ms;
93.	28	no induced atrial fibrillation.
94.	28	Applicants with asthma requiring medication or experiencing recurrent attacks of asthma may be assessed as fit if the asthma is considered stable with satisfactory pulmonary function tests and medication is compatible with flight safety. Systemic steroids should be assessed. As unfit ~~are disqualifying.~~ Inflammatory disease
95.	29	at revalidation, 6 weeks following full recovery from a single spontaneous pneumothorax, with a multi-pilot limitation; OML
96.	30	(f) Digestive tract and Abdominal surgery
97.	30	Abdominal surgery for medical conditions of the digestive tract or its adnexa, including a total or partial excision or a diversion of any of these organs or herniae should be assessed as unfit ~~is disqualifying for a minimum of 3 months~~. An earlier fit assessment may be considered if recovery is complete, the applicant is asymptomatic and there is only a minimal risk of secondary complication or recurrence.
98.	30	Liver disease
99.	30	Applicants with morphological or functional liver disease, or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.
100.	30	Applicants with a Body Mass Index □ 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the applicable licence(s) and a satisfactory cardiovascular risk review

#	Page	Proposed Alternative
		has been undertaken and evaluation of the possibility of sleep apnea are satisfactory, with TML of 6 months or less duration.
101.	31	Addison's disease is disqualifying. A fit assessment may be considered, provided that cortisone is carried and available for use whilst exercising the privileges of the licence(s). Applicants may be assessed as fit with a multi-pilot limitation OML.
102.	31	the use of antidiabetic medications that are not likely to cause hypoglycaemia may be acceptable for a fit assessment with a multi-pilot limitation OML .
103.	31	Polycythaemia (Erythrocytosis)
104.	31	Applicants with polycythaemia (Erythrocytosis) should be assessed as unfit and require investigation. A fit assessment with a multi-pilot limitation may be considered if the condition is stable and no associated pathology is demonstrated.
105.	32	Applicants with thrombocytopenia with a platelet count less than 75x109/L should be assessed as unfit. A fit assessment may be considered once the platelet count is above 75x109/L and stable.
106.	32	Applicants with a thrombotic disorder require investigation. A fit assessment with a multi-pilot limitation OML may be considered when the applicant is asymptomatic and there is only minimal risk of secondary complication or recurrence ~~if there is no history~~ of significant clotting episodes.
107.	32	~~An arterial embolus is disqualifying~~Applicants with arterial embolus should be assessed as unfit. A fit assessment may be considered once recovery is complete, the applicant is asymptomatic, and there is only minimal risk of secondary complication or recurrence~~.~~.
108.	32	If anticoagulation is used as treatment, refer to AMC1 MED.B.010(g).
109.	33	The requirement for dialysis should be assessed as unfit ~~is disqualifying~~.
110.	33	~~With~~Applicants with parenchymal residual calculi, a fit assessment with a multi-pilot limitation may be considered.
111.	33	Applicants who have undergone a major surgical operation on the genitourinary tract or its adnexa ~~the urinary apparatus~~ involving a total or partial excision or a diversion of any of its organs should be assessed as unfit for a minimum period of 3 months or until such time as the effects of the operation are no longer likely to cause incapacity in flight. After other urological surgery, a fit assessment may be considered if the applicant is completely asymptomatic and there is minimal risk of secondary complication or recurrence.
112.	34	Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy. Applicants with quiescent or healed lesions may be assessed as fit.
113.	34	Acute syphilis should be assessed as unfit~~is disqualifying~~. A fit assessment may be considered in the case of those fully treated and recovered from the primary and secondary stages.
114.	34	Infectious hepatitis is disqualifying. A fit assessment may be considered after full recovery, Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.
115.	34	An applicant with a history of severe menstrual disturbances unamenable to treatment should be assessed as unfit. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic.
116.	34	The AeMC or AME should provide written advice to the applicant and the supervising physician regarding potentially significant complications of flying during pregnancy.
117.	35	An applicant with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission and the applicant is taking no disqualifying medication and has satisfactorily completed a medical flight or simulator flight test. ~~A~~ Appropriate limitation to specified aircraft type(s) may be required.
118.	35	Applicants with ~~A~~ abnormal musculoskeletal physique, including obesity, or muscular weakness may require medical flight or flight simulator testing. Particular attention should be paid to emergency procedures and evacuation. ~~A~~ Appropriate limitation or to specified aircraft type(s) may be required.
119.	35	AMC1 MED.B.055 ~~Psychiatry~~ (Mental Health)
120.	35	Mental health assessment as part of the initial class 1 aero-medical examination :
121.	35	(1) A comprehensive mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.

#	Page	Proposed Alternative
122.	35	(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.
123.	35	(3) The mental health assessment should include assessment and documentation of:
124.	35	general attitudes to mental health, including understanding possible indications of reduced mental health in themselves and others;
125.	35	coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;
126.	35	childhood behavioural problems;
127.	35	interpersonal and relationship issues;
128.	35	current work and life stressors; and
129.	35	overt personality disorders.
130.	35	(4) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.
131.	35	Mental health assessment as part of revalidation or renewal class 1 medical examination
132.	35	(1) The assessment should include review and documentation of:
133.	35	current work and life stressors;
134.	35	coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;
135.	35	any difficulties with operational crew resource management (CRM);
136.	35	any difficulties with employer and/or other colleagues and managers; and
137.	35	interpersonal and relationship issues, including difficulties with relatives, friends, and work colleagues.
138.	36	(2) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.
139.	36	(3) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).
140.	36	Assessment of holders of a class 1 medical certificate referenced in MED.B.055(d)
141.	36	Assessment of holders of a class 1 medical certificate referenced in MED.B.055(d) may require psychiatric and psychological evaluation as determined by the medical assessor of the DGCA. A SIC limitation should be imposed in case of a fit assessment. Follow-up and removal of SIC limitation, as necessary, should be determined by the medical assessor of the DGCA.
142.	36	Psychoactive substance testing
143.	36	(1) Drug tests should screen for opioids, cannabinoids, amphetamines, cocaine, hallucinogens and sedative hypnotics. Following a risk assessment performed by a competent authority on the target population, screening tests may include additional drugs.
144.	36	(2) For renewal/revalidation, random psychoactive substance screening test may be performed based on the risk assessment by a competent authority on the target population. If random psychoactive substance screening test is considered, it should be performed and reported in accordance with the procedures developed by a competent authority.
145.	36	(3) In the case of a positive psychoactive substance screening result, confirmation should be required in accordance with national standards and procedures for psychoactive substance testing.
146.	36	(4) In case of a positive confirmation test, a psychiatric evaluation should be undertaken before a fit assessment may be considered by the medical assessor of the DGCA.
147.	36	~~-~~Assessment and referral decisions
148.	37	A history, or the occurrence, of a functional psychotic disorder should be assessed as unfit . ~~is disqualifying unless a cause can be~~ A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and will not recur.

#	Page	Proposed Alternative
149.	37	Applicant with ~~An~~ an organic mental disorder ~~is disqualifying~~ should be assessed as unfit. Once the cause has been treated, an applicant may be assessed as fit following satisfactory psychiatric review.
150.	37	Psychotropic substances or medication:
151.	37	Use or abuse of psychotropic substances or medication that is likely to affect flight safety is disqualifying.
152.	37	Applicants who use psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with an OML may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed
153.	37	An established mood disorder ~~is disqualifying~~ should be assessed as unfit. After full recovery and after full consideration of an individual case a fit assessment may be considered, depending on the characteristics and gravity of the mood disorder. If a stable maintenance psychotropic medication is confirmed, a fit assessment should require a multi-pilot limitation.
154.	37	Applicant with mental ~~Mental~~ or behavioural disorders due to alcohol or other substance use, with or without dependency, should be assessed as unfit~~are disqualifying~~.
155.	37	in-patient treatment of some weeks of inclusion into support programme with regular reports followed by:
156.	38	Applicants who have carried out a ~~A~~ single self-destructive action or repeated acts of deliberate self-harm should be assessed as unfit~~are disqualifying~~. A fit assessment may be considered after full consideration of an individual case and may require psychiatric or psychological review. Neuropsychological assessment may also be required.
157.	38	Assessment
158.	38	The assessment should take into consideration if the indication for the treatment, side effects and addiction risks of such treatment and the characteristics of the psychiatric disorder are compatible with flight safety.
159.	38	Specialist opinion and advice
160.	38	(1) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC or medical assessor of the DGCA as appropriate, detailing their opinion and recommendation.
161.	38	(2) Psychiatric evaluations should be conducted by a qualified psychiatrist having adequate knowledge and experience in aviation medicine.
162.	38	(3) The psychological opinion and advice should be based on a clinical psychological assessment conducted by a suitably qualified and accredited clinical psychologist with expertise and experience in aviation psychology.
163.	38	(4) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and clinical interview.
164.	38	AMC2 MED.B.055 Mental health
165.	38	Mental health assessment as part of class 2 aero-medical examination
166.	38	(1) A mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.
167.	38	(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.
168.	38	(3) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.
169.	38	(4) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).
170.	38	Assessment of holders of a class 2medical certificate referenced in MED.B.055(d)
171.	38	Assessment of holders of a class 2 medical certificate referenced in MED.B.055(d) may require psychiatric and psychological evaluation as determined by the AME, AeMC or medical assessor of the licensing authority. Follow-up, as necessary, should be determined in consultation with the medical assessor of the licensing authority.

#	Page	Proposed Alternative
172.	39	Assessment and referral decisions
173.	39	(1) Psychotic disorder
174.	39	Applicants with a history, or the occurrence, of a functional psychotic disorder should be assessed as unfit. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased and the risk of recurrence is minimal.
175.	39	(2) Organic mental disorder
176.	39	Applicants with an organic mental disorder should be assessed as unfit. Once the cause has been treated, an applicant may be assessed as fit following satisfactory psychiatric evaluation.
177.	39	(3) Schizophrenia, schizotypal or delusional disorder
178.	39	Applicants with an established history or clinical diagnosis of schizophrenia, schizotypal or delusional disorder may only be considered for a fit assessment in consultation with the medical assessor of the licensing authority if the original diagnosis was inappropriate or inaccurate as confirmed by psychiatric evaluation, or, in the case of a single episode of delirium of which the cause was clear, provided that the applicant has suffered no permanent mental impairment.
179.	39	(4) Mood disorder
180.	39	Applicants with an established mood disorder should be assessed as unfit. After full recovery and after full consideration of the individual case, a fit assessment may be considered, depending on the characteristics and severity of the mood disorder.
181.	39	(5) Neurotic, stress-related or somatoform disorder
182.	39	Where there are signs or is established evidence that an applicant may have a neurotic, stress-related or somatoform disorder, the applicant should be referred for psychiatric opinion and advice.
183.	39	(6) Personality or behavioural disorders
184.	39	Where there are signs or is established evidence that an applicant may have a personality or behavioural disorder, the applicant should be referred for psychiatric opinion and advice.
185.	39	(7) Psychoactive medication
186.	39	Applicants who use psychoactive medication likely to affect flight safety should be assessed as unfit. If stability on maintenance psychoactive medication is confirmed, a fit assessment with an OSL or OPL may be considered. If the dosage or type of medication is changed, a further period of unfit assessment should be required until stability is confirmed.
187.	39	(8) Disorders due to alcohol or other psychoactive substance(s) use or misuse
188.	39	Applicants with mental or behavioural disorders due to alcohol or other psychoactive substance(s) use or misuse, with or without dependency, should be assessed as unfit.
189.	39	Drug and alcohol tests
190.	39	In the case of a positive drug or alcohol result, confirmation should be required in accordance with national procedures for drugs and alcohol testing.
191.	40	In case of a positive confirmation test, a psychiatric evaluation should be undertaken before a fit assessment may be considered.
192.	40	A fit assessment may be considered after a period of two years of documented sobriety or freedom from psychoactive substance use or misuse. At revalidation or renewal, a fit assessment may be considered earlier with an OSL or OPL. Depending on the individual case, treatment and evaluation may include in-patient treatment of some weeks and inclusion into a support programme followed by ongoing checks, including drug and alcohol testing and reports resulting from the support programme, which may be required indefinitely.
193.	40	(9) Deliberate self-harm
194.	40	Applicants who have carried out a single self-destructive action or repeated acts of deliberate self-harm or suicide attempt should be assessed as unfit. A fit assessment may be considered after full consideration of an individual case and may require psychiatric or psychological evaluation. Neuropsychological evaluation may also be required.
195.	40	Specialist opinion and advice

#	Page	Proposed Alternative
196.	40	(1) In case a specialist evaluation is needed, following the evaluation, the specialist should submit a written report to the AME, AeMC or medical assessor of the licensing authority as appropriate, detailing their opinion and recommendation.
197.	40	(2) Psychiatric evaluations should be conducted by a qualified psychiatrist having adequate knowledge and experience in aviation medicine.
198.	40	(3) The psychological opinion and advice should be based on a clinical psychological assessment conducted by a suitably qualified and accredited clinical psychologist with expertise and experience in aviation psychology.
199.	40	(4) The psychological evaluation may include a collection of biographical data, the administration of aptitude as well as personality tests and clinical interview.
200.	40	GM1 MED.B.055 Mental health
201.	40	Symptoms of concern may include but are not limited to:
202.	40	(1) use of alcohol or other psychoactive substances;
203.	40	(2) loss of interest/energy;
204.	40	(3) eating and weight changes;
205.	40	(4) sleeping problems;
206.	40	(5) low mood and, if present, any suicidal thoughts;
207.	40	(6) family history of psychiatric disorders, particularly suicide;
208.	40	(7) anger, agitation or high mood; and
209.	41	(8) depersonalisation or loss of control.
210.	41	The following aspects should be taken into consideration when conducting the mental health examination:
211.	41	(1) Appearance;
212.	41	(2) Attitude;
213.	41	(3) Behaviour;
214.	41	(4) Mood;
215.	41	(5) Speech;
216.	41	(6) Thoughts process and content;
217.	41	(7) Perception;
218.	41	(8) Cognition;
219.	41	(9) Insight; and
220.	41	(10) Judgement.
221.	41	GM2 MED.B.055 Mental health
222.	41	Drugs and alcohol screening tests used should:
223.	41	(1) provide information regarding medium-term consumption;
224.	41	(2) be accepted on national level by the competent authority based on the availability and suitability for the scope mentioned in point(a)(1) above.
225.	41	Statistical data of the screening campaign mentioned in AMC1 MED.B.055(d)(1) should be made available to the Agency on a yearly basis.
226.	41	AMC1 MED.B.060 Psychology
227.	42	A diagnosis of epilepsy should be assessed as unfit~~is disqualifying~~, unless there is unequivocal evidence of a syndrome of benign childhood epilepsy associated with a very low risk of recurrence, and unless the applicant has been free of recurrence and off treatment for more than 10 years. One or more convulsive episodes after the age of 5 are disqualifying. In the case of an acute symptomatic seizure, which is

#	Page	Proposed Alternative
		considered to have a very low risk of recurrence, a fit assessment may be considered after neurological review.
228.	43	In the case of a single episode of disturbance of consciousness, which can be satisfactorily explained, a fit assessment may be considered, but a recurrence should ~~be disqualifying~~ should be assessed as unfit.
229.	43	Vascular deficiencies
230.	43	Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC1 MED.B.050 are satisfied. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.
231.	43	Migraine
232.	43	Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, therapy. Appropriate limitation(s) may apply.
233.	44	visual fields;
234.	44	~~visual fields;~~ tonometry on clinical indication; and
235.	44	objective refraction: hyperopic initial applicants with a hyperopia of more than +2 dioptres and under the age of 25 should undergo objective refraction in cycloplegia;~~refraction hyperopic initial applicants with a hyperopia of more than +2 dioptres and under the age of 25 should undergo objective refraction in cycloplegia~~.
236.	44	assessment of mesopic contrast sensitivity; and
237.	44	Refractive error and anisometropia
238.	45	hypermetropia exceeds +5.0 dioptres;
239.	45	anisometropia exceeds 3.0 dioptres
240.	45	(the refractive error is between –3.0 and –6.0 dioptres or +3 and +5 dioptres;
241.	45	astigmatism or anisometropia is between 2.0 and 3.0 dioptres.~~hypermetropia not exceeding +5.0 dioptres;~~ ~~myopia exceeding –6.0 dioptres;~~ (4) An evaluation by an eye specialist should be undertaken 2-yearly if:
242.	45	the refractive error is greater than –6.0 dioptres or +5.0 dioptres;
243.	45	astigmatism or anisometropia exceeds 3.0 dioptres. ~~astigmatism exceeding 2.0 dioptres;~~ ~~anisometropia exceeding 2.0 dioptres~~ provided that optimal correction has been considered and no significant pathology is demonstrated.
244.	46	Cataract or intraocular lens surgery entails unfitness. A fit assessment may be considered after 3 months once recovery is complete and the visual requirements are met with or without correction. Intraocular lenses should be monofocal and should not impair colour vision and night vision .
245.	47	~~For (2), (3) and (4) above, a fit assessment may be considered earlier if recovery is complete.~~ Correcting lenses
246.	47	lantern testing with a Spectrolux, Beynes or Holmes-Wright lantern. This test is considered passed if the applicant passes without error a test with accepted lanterns~~.~~
247.	47	Colour Assessment and Diagnosis (CAD) test.
248.	47	This test is considered passed if the threshold is less than 6 standard normal (SN) units for deutan deficiency, or less than 12 SN units for protan deficiency. A threshold greater than 2 SN units for tritan deficiency indicates an acquired cause which should be investigated.
249.	48	A significant, acute or chronic infection of the oral cavity or upper respiratory tract should be assessed as unfit ~~is disqualifying~~. A fit assessment may be considered after full recovery.
250.	48	) Air passage restrictions
251.	48	Applicants with significant restriction of the nasal air passage on either side, or significant malformation of the oral cavity or upper respiratory tract may be assessed as fit if ENT evaluation is satisfactory.

#	Page	Proposed Alternative
252.	48	) Eustachian tube(s) dysfunction
253.	48	Applicants with permanent dysfunction of the Eustachian tube(s) may be assessed as fit if ENT evaluation is satisfactory.
254.	48	) Sequelae of surgery of the internal or middle ear
255.	48	Applicants with sequelae of surgery of the internal or middle ear should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.
256.	48	GM1 MED.B.080 Otorhinolaryngology (ENT)
257.	48	PURE TONE AUDIOGRAM
258.	49	The pure tone audiogram may also cover the 4 000 Hz frequency for early detection of decrease in hearing.
259.	49	Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.
260.	50	Class Two ~~PPL,SPL,BPL~~
261.	50	Applicants with an aneurysm of the thoracic or supra renal abdominal aorta of less than 5 cm may be assessed as fit with ORL or OSL, subject to satisfactory cardiological evaluation and regular follow-up.
262.	50	Applicants may be assessed as fit after surgery for a thoracic or abdominal or supra renal aortic aneurysm subject to satisfactory cardiological evaluation to exclude the presence of coronary artery disease.
263.	50	Applicants with an aneurysm of the infra-renal abdominal aorta of less than 5 cm in diameter may be assessed as fit, subject to satisfactory cardiological evaluation. Regular cardiological evaluations should be carried out.
264.	50	(3) Aortic valve disease
265.	51	Applicants with a bicuspid aortic valve may be assessed as fit if no other cardiac or aortic abnormality is demonstrated. Follow-up with echocardiography, as necessary, should be determined in consultation with the DGCA medical assessor.
266.	51	Applicants with aortic stenosis may be assessed as fit provided the left ventricular function is intact and the mean pressure gradient is less than 20 mmHg. Applicants with an aortic valve orifice of more than 1 cm2 and a mean pressure gradient above 20 mmHg, but not greater than 50 mmHg, may be assessed as fit with an ORL or OSL. Follow-up with 2D Doppler echocardiography, as necessary, should be determined in consultation with DGCA medical assessor in all cases. Alternative measurement techniques with equivalent ranges may be used. Regular cardiological evaluation should be considered. Applicants with a history of systemic embolism or significant dilatation of the thoracic aorta should be assessed as unfit.
267.	51	Applicants with trivial aortic regurgitation may be assessed as fit. Applicants with a greater degree of aortic regurgitation may be assessed as fit with an OSL. There should be no demonstrable abnormality of the ascending aorta on 2D Doppler echocardiography. Follow-up, as necessary, should be determined in consultation with the medical assessor of the licensing authority.
268.	51	(4) Mitral valve disease
269.	51	Asymptomatic applicants with an isolated mid-systolic click due to mitral leaflet prolapse may be assessed as fit.
270.	51	Applicants with rheumatic mitral stenosis should be assessed as unfit.
271.	51	Applicants with minor regurgitation may be assessed as fit. Periodic cardiological review should be determined in consultation with the medical assessor of the licensing authority.
272.	51	Applicants with moderate mitral regurgitation may be considered as fit with an ORL or OSL if the 2D Doppler echocardiogram demonstrates satisfactory left ventricular dimensions and satisfactory myocardial function is confirmed by exercise electrocardiography. Periodic cardiological review should be determined in consultation with DGCA medical assessor.
273.	51	Applicants with evidence of volume overloading of the left ventricle demonstrated by increased left ventricular end-diastolic diameter or evidence of systolic impairment should be assessed as unfit.
274.	52	Applicants with a history of recurrent vasovagal syncope may be assessed as unfit.A fit assessment may be consider after a 6-month period without recurrence, provided that cardiological evaluation is satisfactory. Neurological review may be indicated.

#	Page	Proposed Alternative
275.	52	A single episode of vasovagal syncope which can be explained and is compatible with flight safety, a fit assessment may be considered
276.	53	Chest pain of uncertain cause requires full investigation. evidence of exercise-induced myocardial ischaemia should be assessed as unfit.
277.	53	After coronary artery bypass grafting, a myocardial perfusion scan (or satisfactory equivalent test) should be performed if there is any indication, and in all cases within five years from the procedure for a fit assessment without an OSL,OPL,ORL ~~a safety pilot~~ limitation.
278.	54	Successful completion of the six month or subsequent review will allow a fit assessment. Applicants may be assessed as fit with an ORL or OSL ~~a safety pilot~~ limitation having successfully completed only an exercise ECG.
279.	54	Angina pectoris should be assessed as unfit ~~is disqualifying~~, whether or not it is abolished by medication.
280.	54	Applicants with complete right bundle branch block may be assessed as fit with appropriate limitations, such as an ORL subject to satisfactory cardiological evaluation.
281.	54	Applicants with complete left bundle branch block may be assessed as fit with appropriate limitations, such as an ORL subject to satisfactory cardiological assessment.
282.	55	Asymptomatic applicants with ventricular pre-excitation may be assessed as fit subject to satisfactory cardiological evaluation and an electrophysiological study is conducted and the results are satisfactory .
283.	55	Applicants with a subendocardial pacemaker may be assessed as unfit. A fit assessment may be considered no sooner than 3 months after insertion provided:
284.	55	(8) QT prolongation
285.	55	Applicants with asymptomatic QT prolongation may be assessed as fit with an ORL or OSL subject to satisfactory cardiological evaluation.
286.	55	(9) Brugada pattern on electrocardiography
287.	55	Applicants with a Brugada pattern Type 1 should be assessed as unfit. Applicants with Type 2 or Type 3 may be assessed as fit, with limitation(s) as appropriate, subject to satisfactory cardiological evaluation.
288.	55	Applicants with asthma may be assessed as fit if the asthma is considered stable with satisfactory spirometric pulmonary function tests and medication is compatible with flight safety. Systemic steroids should be disqualifying.
289.	56	Applicants requiring major thoracic surgery should be assessed as unfit until recovery and ~~such time as~~ the effects of the operation are no longer likely to interfere with the safe exercise of the privileges of the applicable licence(s). Pneumonectomy should be assessed as unfit.
290.	56	Abdominal surgery as unfit ~~is disqualifying~~. A fit assessment may be considered if recovery is complete, the applicant is asymptomatic and there is only a minimal risk of secondary complication or recurrence.
291.	57	~~(g)~~ Liver disease
292.	57	Applicants with morphological or functional liver disease, or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.
293.	57	Obese applicants may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the applicable licence(s). Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken with TML of at least 6 months duration or less.
294.	57	~~.~~ Addison's disease
295.	58	Polycythaemia (Erythrocytosis)
296.	58	Applicants with polycythaemia (Erythrocytosis) may be assessed as fit if the condition is stable and no associated pathology is demonstrated.
297.	59	AMC2 MED.B.040 Infectious disease
298.	59	Tuberculosis
299.	59	(1) Applicants with active tuberculosis should be assessed as unfit. A fit assessment may be considered following completion of therapy.

#	Page	Proposed Alternative
300.	60	(2) Applicants with quiescent or healed lesions may be assessed as fit. Specialist evaluation should consider the extent of the disease, the treatment required and possible side effects of medication.
301.	60	HIV positivity
302.	60	Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)
303.	60	An applicant who has undergone a major gynaecological operation should be assessed as unfit until recovery is complete, the applicant is asymptomatic ~~such time as~~ and the effects of the operation are not likely to interfere with the safe exercise of the privileges of the licence(s).
304.	60	AMC2 MED.B.055 ~~Psychiatry~~ ~~(~~Mental Health~~)~~
305.	60	Mental health assessment as part of class 2 aero-medical examination
306.	60	(1) A mental health assessment should be conducted and recorded taking into account social, environmental and cultural contexts.
307.	61	(2) The applicant's history and symptoms of disorders that might pose a threat to flight safety should be identified and recorded.
308.	61	(3) Where there are signs or is established evidence that an applicant may have a psychiatric or psychological disorder, the applicant should be referred for specialist opinion and advice.
309.	61	(4) Established evidence should be verifiable information from an identifiable source related to the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, behaviour or knowledge relevant to the safe exercise of the privileges of the applicable licence(s).
310.	61	Assessment of holders of a class 2 medical certificate
311.	61	Assessment of holders of a class 2 medical certificate may require psychiatric and psychological evaluation as determined by the AME, AeMC or DGCA medical assessor. Follow-up, as necessary, should be determined in consultation with the DGCA medical assessor.
312.	61	A history, or the occurrence, of a functional psychotic disorder ~~is disqualifying unless~~should be assessed as unfit. A fit assessment may be considered if in certain rare cases a cause can be unequivocally identified as one which is transient, has ceased and will not recur.
313.	61	~~History of a single or repeated acts of self-harm should be assessed as unfit~~.
314.	62	History of a single or repeated acts of self-harm should be assessed as unfit.
315.	62	Personality or behavioural disorders
316.	62	Where there are signs or is established evidence that an applicant may have a personality or behavioural disorder, the applicant should be referred for psychiatric opinion and advice.
317.	62	Neurotic, stress-related or somatoform disorder
318.	62	Where there are signs or is established evidence that an applicant may have a neurotic, stress-related or somatoform disorder, the applicant should be referred for psychiatric opinion and advice.
319.	62	GM1 MED.B.055 Mental health
320.	62	The mental health assessment for class 2 applicants should include assessment and documentation of:
321.	62	(1) general attitudes to mental health, including understanding possible indications of reduced mental health in themselves and others;
322.	62	(2) coping strategies under periods of psychological stress or pressure in the past, including seeking advice from others;
323.	62	(3) childhood behavioural problems;
324.	62	(4) interpersonal and relationship issues, including difficulties with relatives, friends, and work colleagues;
325.	62	(5) current work and life stressors, including difficulties with aviation operational environment; and
326.	62	(6) overt personality disorders.
327.	62	In regard to symptoms of concern and aspects to be taken into consideration when conducting mental health examination for class 2 applicants, guidance presented in GM1 MED.B.055 should be used.

#	Page	Proposed Alternative
328.	62	GM2 MED.B.055 Mental health
329.	62	Drugs and alcohol screening tests used should:
330.	62	provide information regarding medium-term consumption;
331.	62	be accepted on national level by the competent authority based on the availability and suitability with the scope mentioned in GM2 MED.B.055(a) above.
332.	63	(e) Migraine
333.	63	Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, and therapy. Appropriate limitation(s) may apply.
334.	63	Spinal or peripheral nerve injury
335.	63	Applicants with a history or diagnosis of spinal or peripheral nerve injury or a disorder of the nervous system due to a traumatic injury should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the conditions of AMC2 MED.B.050 are satisfied.
336.	63	Vascular deficiencies
337.	63	Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory and the provisions of AMC2 MED.B.050 are met. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.
338.	65	Colour Assessment and Diagnosis (CAD) test. This test is considered passed if the threshold is less than 6 standard normal (SN) units for deutan deficiency, or less than 12 SN units for protan deficiency. A threshold greater than 2 SN units for tritan deficiency indicates an acquired cause which should be investigated.
339.	67	Sequelae of surgery of the internal or middle ear
340.	67	Applicants with sequelae of surgery of the internal or middle ear should be assessed as unfit until recovery is complete, the applicant is asymptomatic, and the risk of secondary complication is minimal.
341.	67	Applicants receiving ongoing chemotherapy or radiation treatment should be assessed as unfit.
342.	68	- Specific Requirements for LAPL ~~including LSA)~~ Medical Certificates
343.	68	After cardiac valve replacement or repair a fit assessment may be considered if post-operative cardiac function and investigations are satisfactory with an ORL . Anticoagulation, if needed, should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.
344.	68	Applicants with other cardiac disorders may be assessed as fit subject to satisfactory cardiological assessment with an ORL.
345.	69	Applicants with a significant disturbance of cardiac rhythm or conduction should be assessed as unfit unless a cardiological evaluation concludes that the disturbance is not likely to interfere with the safe exercise of the privileges of the LAPL. A fit assessment may be considered, with an ORL if anticoagulation is needed. Anticoagulation should be stable and the haemorrhagic risk should be acceptable. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range.
346.	69	(4) Automatic implantable defibrillating system
347.	69	Applicants with an automatic implantable defibrillating system should be assessed as unfit.
348.	70	(e) Liver disease
349.	70	Applicants with morphological or functional liver disease or after surgery, including liver transplantation, may be assessed as fit subject to satisfactory gastroenterological evaluation.
350.	71	Obese applicants may be assessed as fit if the excess weight is not likely to interfere with the safe exercise of the licence. Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken with TML of at least 6 months duration.

#	Page	Proposed Alternative
351.	73	Applicants who have undergone renal transplantation may be assessed as fit subject to satisfactory renal evaluation.
352.	73	Applicants with other chronic infections may be assessed as fit provided the infections are not likely to interfere with the safe exercise of the privileges of the licence.
353.	74	AMC11 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Psychiatry) Mental health
354.	74	At revalidation ~~Applicants~~ applicants with a mental or behavioural disorder due to alcohol or other substance use should be assessed as unfit pending recovery after a period of two years of documented sobriety or ~~-~~and freedom from substance use and subject to satisfactory psychiatric evaluation after treatment.
355.	74	~~AMC12 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates~~ (Psychology)
356.	74	Applicants with a psychological disorder may need to be referred for psychological opinion and advice. A fit assessment may be considered if a cause can be unequivocally identified as one which is transient, has ceased, and the risk of recurrence is minimal.
357.	75	~~AMC13~~ AMC12 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Neurology)
358.	75	(e) Migraine
359.	75	Applicants with an established diagnosis of migraine or other severe periodic headaches likely to cause a hazard to flight safety should be assessed as unfit. A fit assessment may be considered after full evaluation. The evaluation should take into account at least the following: auras, visual field loss, frequency, severity, therapy. Appropriate limitation(s) may apply.
360.	75	(f) Vascular deficiencies
361.	75	Applicants with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological evaluation is satisfactory. A cardiological evaluation and medical flight test should be undertaken for applicants with residual deficiencies.
362.	76	~~AMC14~~ AMC13 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Visual system)
363.	76	~~AMC15~~ AMC14 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Colour vision)
364.	77	~~AMC16~~ AMC15 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Otorhino-laryngology)
365.	77	If the hearing requirements can only be met with the use of hearing aid(s), the hearing aid(s) should provide optimal hearing function, be well-tolerated, and be suitable for aviation purposes.
366.	77	~~AMC17~~ AMC16 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Dermatology)
367.	77	~~AMC18~~ AMC17 MED.B.095 Medical examination and/or assessment of applicants for LAPL medical certificates (Oncology)
368.	78	Applicants with an established history or clinical diagnosis of intracerebral malignant tumour should be assessed as unfit.
369.	79	Intervals
370.	79	(1) The interval between aero-medical assessments should be determined by the DGCA/ASD. The intervals established by the competent authority apply to cabin crew members who:
371.	79	undergo aero-medical assessments by an AM or AeMC under the oversight of DGCA/ASD; or
372.	79	are employed by an operator under the oversight of DGCA/ASD.
373.	79	(2) The interval between aero-medical assessments may be reduced by the AME or AeMC for medical reasons and in accordance with MED.C.035.
374.	79	(3) Aero-medical assessments for the revalidation of a cabin crew medical report may be undertaken up to 45 days prior to the expiry date of the previous medical report. The validity period of the aero-medical assessment should be calculated from the expiry date of the previous aero-medical assessment.

#	Page	Proposed Alternative
375.	80	recurrent vasovagal syncope of uncertain cause ;
376.	81	For recurrent vasovagal syncope fit assessment may be considered after a 6-month period without recurrence, provided cardiological evaluation is satisfactory. Neurological review may be indicated.
377.	81	The blood pressure should be within normal limits of 160 mmHg systolic and/or 95 mmHg diastolic, with or without treatment.
378.	81	(f) Thromboembolic disorders
379.	82	Whilst anticoagulation therapy is initiated, cabin crew members should be assessed as unfit. After a period of stable anticoagulation, a fit assessment may be considered with limitation(s), as appropriate. Anticoagulation should be considered stable if, within the last 6 months, at least 5 INR values are documented, of which at least 4 are within the INR target range and the haemorrhagic risk is acceptable.
380.	82	recurrent dyspeptic disorder including peptic ulcer requiring medication;
381.	82	morphological or functional liver disease; including liver transplantation
382.	83	Applicants with a Body Mass Index > 35 may be assessed as fit only if the excess weight is not likely to interfere with the safe exercise of the privileges of the licence and a satisfactory cardiovascular risk review and evaluation of the possibility of sleep apnoea syndrome has been undertaken with TML of at least 12 months duration.
383.	84	Cabin crew members who have undergone renal transplantation may be considered for a fit assessment if it is fully compensated and tolerated with only minimal immuno-suppressive therapy after at least 12 months. A requirement to undergo specific medical examinations (SIC) and a restriction to operate only in multi-cabin crew operations (MCL) should be considered.
384.	84	Cabin crew members requiring dialysis should be assessed as unfit.
385.	84	AMC8 MED.C.025 Content of aero-medical assessments
386.	84	INFECTIOUS DISEASE
387.	84	Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)
388.	85	A cabin crew member should have satisfactory functional use of the musculoskeletal system. . Particular attention should be paid to emergency procedures and evacuation, and related training.
389.	85	Cabin crew members with any significant sequelae from disease, injury or congenital abnormality affecting the bones, joints, muscles or tendons with or without surgery require full evaluation prior to a fit assessment.
390.	85	Cabin crew members with inflammatory, infiltrative, traumatic or degenerative disease of the musculoskeletal system may be assessed as fit provided the condition is in remission or is stable and the affected cabin crew member is not taking any medication that may lead to unfitness.
391.	85	AMC11 MED.C.025 Content of aero-medical assessments ~~(Psychiatry)~~Mental Health
392.	85	(Psychiatry)
393.	85	(Psychology)
394.	86	~~AMC12 MED.C.025 Content of aero-medical assessments (Psychology)~~ ~~Where there is established evidence that a cabin crew member has a psychological disorder, he/she should be referred for psychological opinion and advice.~~
395.	86	~~AMC13~~ AMC12 MED.C.025 Content of aero-medical assessments (Neurology)
396.	86	Cabin crew members with a disorder of the nervous system due to vascular deficiencies including haemorrhagic and ischaemic events should be assessed as unfit. A fit assessment may be considered if neurological review and musculoskeletal assessments are satisfactory.
397.	87	~~AMC14~~ AMC13 MED.C.025 Content of aero-medical assessments (Visual System)
398.	87	~~AMC15~~ AMC14 MED.C.025 Content of aero-medical assessments (Colour vision)
399.	87	~~AMC16~~ AMC15 MED.C.025 Content of aero-medical assessments (Otorhino-laryngology)
400.	88	(8)If the hearing requirements can be met only with the use of hearing aid(s), the hearing aid(s) should provide optimal hearing function, be well-tolerated, and suitable for aviation purposes.

#	Page	Proposed Alternative
401.	88	~~AMC17~~ AMC16 MED.C.025 Content of aero-medical assessments (Dermatology)
402.	88	~~AMC18~~ AMC17 MED.C.025 Content of aero-medical assessments (Oncology)
403.	93	Respiratory
404.	93	Metabolic and endocrine systems
405.	93	Haematology
406.	93	Genitourinary system
407.	93	Musculoskeletal system
408.	93	Oncology
409.	93	Cabin crew working environment
410.	93	In-flight environment; and
411.	93	Space medicine
412.	94	Advanced training course for AMEs ~~after attending the training on the syllabus for the basic training course~~ The advanced training course for AMEs should consist of another 60 hours of theoretical and practical training, including specific examination techniques.
413.	115	Applicants who are seropositive for Human Immunodeficiency Virus (HIV) shall be assessed as unfit. (Civil Service Commission order 9/93 and Civil Service Law Chapter 1.5 for 04/04/1979)
414.	115	(e) Applicants with other chronic infections may be assessed as fit provided the infections are not likely to interfere with the safe exercise of the privileges of the licence.
415.	122	Pseudoisochromatic plate testing alone is sufficient (Iihara).
416.	123	Colour Assessment and Diagnosis (CAD) test (if available or indicated).
417.	126	Alcohol And Substance Abuse Prevention Policy
418.	126	CAT.GEN.MPA.170 Psychoactive substances
419.	126	(a) The operator shall take all reasonable measures to ensure that no person enters or is in an aircraft when under the influence of psychoactive substances to the extent that the safety of the aircraft or its occupants is likely to be endangered.
420.	126	The operator shall develop and implement a policy on the prevention and detection of misuse of psychoactive substances by flight and cabin crew members and by other safety-sensitive personnel under its direct control, in order to ensure that the safety of the aircraft or its occupants is not endangered.
421.	126	Without prejudice to the applicable national legislation on data protection concerning testing of individuals, the operator shall develop and implement an objective, transparent and on discriminatory procedure for the prevention and detection of cases of misuse of psychoactive substances by its flight and cabin crew and other safetysensitive personnel.
422.	126	(d) In case of a confirmed positive test result, the operator shall inform its competent authority and the authority responsible for the personnel concerned, such as a medical assessor of the Kuwait DGCA.
423.		[TABLE] Revision ~~3~~4 ~~July 2019~~April 2024