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### Download this form before you begin

Please download and complete with Adobe Acrobat. If you are using a browser to complete this form you may lose your information. Send this form and any attachments to [avmed@casa.gov.au](mailto:avmed@casa.gov.au).

### Purpose of this form

Use this form when further information is requested from CASA or when there is a significant change in the severity or frequency of your headaches.

### Who is this form for?

This form is to be completed jointly by the applicant and their DAME or treating doctor to report to CASA severe headaches and migraines in pilots and air traffic controllers so that CASA can investigate the report. This form is not for the reporting of significant medical conditions to CASA for regulation 67.265 of the Civil Aviation Safety Regulations 1998.

### Information needed to complete this form

Complete this form with your DAME or treating doctor. The DAME or treating doctor is responsible for completing and signing CASA's Multi-Party Declaration (MPD) form. This must be submitted with the notification.

### Aviation Reference Number (ARN)

An ARN is required to complete this form. If you do not have an ARN, [apply now](#).

If you are applying on behalf of an organisation, you will need to have authority to act on the entity's (applicant's) behalf and be able to provide the organisation's ARN.

### Contact details

It is important the contact details on the ARN profile are current. CASA uses these contact details when processing this application.

If your address, contact or other details have changed, you must update them prior to lodging this form. You can do this by [changing your details](#) on the CASA website.

Failure to provide up to date contact details to CASA could result in additional fees being charged under the *Civil Aviation (Fees) Regulations 1995* and may constitute a criminal offence.

### For more information

Go to the [CASA website](#) or [contact us](#).

## Notifier

1 What are the **notifier** details?

Your contact details must be current. Update contact details via [changing your details](#).

Legal entity/full name

ARN

Phone number

Email address

## History

2 What is the **history** of your headache(s)?

Date of **first attack** (DD/MM/YYYY)

/ /

Date of **most recent attack** (DD/MM/YYYY)

/ /

Number of headache(s) in the last year

How long does an attack last?

Description of the headache(s)

Written in your own words.

 Provide additional pages if required

**What medication are you taking (if any) for your headaches?**

For symptoms?

For prevention?

## Severity criteria

3 What is the severity of your pain?

Between 1 (mild) and 10 (severe)

4 Do you experience any of the following?

Symptom	No	Yes
Avoidance of routine activity	No	Yes
Distracting	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Photo/phonophobia	No	Yes
Motor or sensory features	No	Yes
Aura	No	Yes
Acute medical/hospital treatment needed	No	Yes

5 If you answered **yes** to **any** of the questions above, you must provide details on the degree of incapacity below.

 Provide additional pages if required

## Severity criteria

6 What is your opinion of the severity of the headache?

Minor Distracting

Distracting (Able to continue but may impair performance) with **no** severity features.

Major Distracting

Continue activity but distracting, plus **one** severity criterion.

Incapacitating

Unable to continue routine activity.

## Predictability factors

7 Do you have any **patterns or triggers** to your headache(s)?

Symptom	No	Yes
Premenstrual	No	Yes
Contraceptive Pill	No	Yes
Weekends	No	Yes
Foods/drinks	No	Yes
Other	No	Yes

8 If you answered **yes** to **any** of the questions above, you must provide details below.

 Provide additional pages if required

9 Do you have any warning signs of the headache(s)?

**No**

**Yes**

How long before the attack?

Describe the warning

 Provide additional pages if required

## Notifier checklist

10 Select/specify attachments:

GP Records (required if obtainable) is attached

Neurologist details is attached

Special Eye Report is attached

Multi-Party Declaration (MPD) Form completed by Doctor and is attached

## Checklist continued

If other please specify

## Doctors details and signature

11 What are the **doctors** details?

Doctors full name

Phone number

Email address

Practice Address or Practice Stamp

Type of ID used to identify clients

Indicate the type of photographic ID sighted, serial number and expiry date.

Signature

The DAME or treating Doctor **must** complete the Multi-Party Declaration (MPD) Form.

This will satisfy the need to confirm the participation and permission from the **Doctor** named in this submission.

As part of this submission process, you can upload the signed declaration form in the supporting the documents section.

**12 I declare:**

- All statements in this notice are true and correct.

I acknowledge by providing my details below and submitting this notice:

- I may commit an offence under the *Criminal Code Act 1995* if I make a false or misleading statement in my notice.
- We may also use your licensing information in deidentified form for aviation safety research/analysis.

**Privacy**

Any personal information you provide to CASA, as part of this notice, is protected by the *Privacy Act 1988*.

We will use the information provided to process this notice and may also use it to conduct identity/security checks. Without your consent, we may not be able to process your notice.

To meet our accountability obligations, we may disclose this information:

- to other government agencies or other national aviation authorities for certain purposes, and
- to comply with court orders and other legal requirements.

For more information about how we use, disclose and protect your personal information, see our [privacy statement](#) and [privacy policy](#).

- I declare and acknowledge the above matters.
- I consent to CASA using my licensing information and other personal information for the above purposes.
- I have read CASA's privacy policy and I authorise CASA to use and disclose the information it collects for this notice in accordance with that policy.

Full name

Signature

Date (DD/MM/YYYY)

/ /

**Submitting this form to CASA**

**Choose one option only**



By email – send this form with all supporting documents attached to [avmed@casa.gov.au](mailto:avmed@casa.gov.au)



By post – return this form and all supporting documents to:

**CASA Client Services Centre  
GPO Box 2005  
Canberra ACT 2601**