



Appointment or Reappointment as Designated Aviation Medical Examiner or Designated Aviation Ophthalmologist

CASR 67.025

Purpose of this form

Use this form to apply to CASA for appointment or reappointment as a Designated Aviation Medical Examiner (DAME) or Designated Aviation Ophthalmologist (DAO).

Who is this form for?

This form is for registered medical professionals applying for DAME or DAO appointment or reappointment.

Information needed to complete this form

You are required to provide the following:

- Certified Av med/FranzCO Qualification (new appointments only)
- CASA Regulatory Course certificate (new appointments only)
- Evidence of current medical registration
- Curriculum Vitae (new appointments only)
- Certificates of attendance at Aviation Medicine Education or RANZCO (CPD - reappointments only)
- Colour photograph



We recommend using Adobe Acrobat to complete this form to ensure your information is saved correctly

Filling in this form

This form can be completed as a **fillable form**:

- Adobe Reader is available free of charge from the [Adobe website](#)
- use 'tab' or 'mouse click' to navigate through the form
- 'mouse click' on the '➔ Go to' button to skip to the question

If **printing** this form:

- use black or blue pen and print in BLOCK LETTERS
- mark check boxes with a ✓ or a ✗
- if you see '➔ Go to' go to the question number shown, you do not need to answer the questions in between

Aviation Reference Number (ARN)

An ARN is an identifier that is similar to an account or customer number. You will need an ARN to complete this form.

If you do not have an ARN, [apply for an ARN](#).

Contact details

CASA will use the currently held contact details linked to your ARN profile.

If your address, contact or other details have changed, you must update them online using [changing your details](#) prior to lodging this form.

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.

Privacy

Any personal information you provide to CASA is protected by the Privacy Act 1988 (Cth). CASA can only collect, use and disclose that information in accordance with that Act.

CASA will use the information collected in this form for purposes associated with performing its functions under civil aviation legislation and other Australian laws.

For full details on how CASA collects, protects and uses personal information, please refer to [CASA Privacy Policy](#).

For more information

Go to the [CASA website](#) or call us on 131 757.

Applicant

1 What are the **applicant** details?

If your address, contact or other details have changed, you must update them using [changing your details](#).

Your **title**, **family name/surname** and **gender** will be published on the CASA website

Title

Miss Mrs Ms
Mr Prof Dr

First given name(s)

Family name/surname

ARN

Date of birth (DD/MM/YYYY)

/ /

Gender identity

Male Female
Undefined

Contact details

2 What are your **contact** and **postal address** details?

Contact number

Email address

Unit/number

Street name/PO box

Suburb

State/territory

Postcode

Country (if not Australia)

 **Attach coloured photograph**

3 What is the **appointment type** (select one)?

DAME
DAO

4 What are you **applying** for (select one)?

New Appointment
Reappointment

5 What is your **examiner number**?

Qualifications and Experience

6 Which university or medical school did you obtain your qualification?

Qualification obtained


 **Attach certified copy of qualifications**

7 What higher qualifications have you obtained?


DAO applicants must attach FRANZCO or equivalent.
Attach CASA aviation medicine regulatory course certificate (DAME/DAO)

 **Attach higher qualifications**

8 What is the type of practice and or/registered specialty?

 **Attach evidence of current medical registration**

9 What experience do you have in aviation medicine?

 **Attach copy of curriculum vitae**

10 Are you a pilot?

No

Yes

11 What is your category?

ATPL

CPL

PPL

RPL

12 What are your current memberships (select all that apply)?

ASAM

AMSNZ

ASMA

ICASM

ESAM

Other (specify)

 **Attach copy of membership certificates**

13 What affiliation(s) do you have with aero/space medical organisations?

14 Are you approved to conduct medicals for overseas flight crew licencing authorities?

No

Yes

15 Which country/countries are you approved in?

Continuing professional development

16 What aeromedical meetings have you attended in the last three years?

Date attended (DD/MM/YYYY)

/ /

Organisation

Location

Date attended (DD/MM/YYYY)

/ /

Organisation

Location

Date attended (DD/MM/YYYY)

/ /

Organisation

Location

Date attended (DD/MM/YYYY)

/ /

Organisation


Location

Date attended (DD/MM/YYYY)

/ /

Organisation

Location

 **Attach copy of attendance certificates**

Practice Detail(s)

17 What are the practice detail(s)?

Your **Website** and **Physical location(s)** will be published on the CASA website.

Practice name

Average hours per week at this location

Physical address (including city, state/region, postcode, country)

Website address

Contact number

Fax number

Email address

Practice name

Average hours per week at this location

Physical address (including city, state/region, postcode, country)

Website address

Contact number

Fax number

Email address

17 Continued

Practice name

Average hours per week at this location

Physical address (including city, state/region, postcode, country)

Website address

Contact number

Fax number

Email address

Practice name

Average hours per week at this location

Physical address (including city, state/region, postcode, country)

Website address

Contact number

Fax number

Email address

 **Attach additional pages if required**

Practice Staff

18 Which practice staff will need access to the Medical Records System (MRS)?

Please list any nurses, receptionists or other staff that require access. Each staff member will **require** an individual ARN

Title

Miss Mrs Ms
Mr Prof Dr

Full name

ARN

Date of birth (DD/MM/YYYY)

/ /

Position/role (Nurse, Receptionist)

Title

Miss Mrs Ms
Mr Prof Dr

Full name

ARN

Date of birth (DD/MM/YYYY)

/ /

Position/role (Nurse, Receptionist)

Title

Miss Mrs Ms
Mr Prof Dr

Full name

ARN

Date of birth (DD/MM/YYYY)

/ /

Position/role (Nurse, Receptionist)

18 Continued

Title

Miss Mrs Ms
Mr Prof Dr

Full name

ARN

Date of birth (DD/MM/YYYY)

/ /

Position/role (Nurse, Receptionist)

Title

Miss Mrs Ms
Mr Prof Dr

Full name

ARN

Date of birth (DD/MM/YYYY)

/ /

Position/role (Nurse, Receptionist)

Title

Miss Mrs Ms
Mr Prof Dr

Full name

ARN

Date of birth (DD/MM/YYYY)

/ /

Position/role (Nurse, Receptionist)

 **Attach additional pages if required**

Application checklist

19 Select/specify attachments:

New appointment

Colour photograph is attached

Certified copy of Av med/Franzco Qualification is attached

CASA Regulatory Course Certificate is attached

Evidence of Current Medical Registration is attached

Curriculum vitae is attached

Reappointment

Colour photograph is attached

Listed attended Aviation Medicine Education CPD/
RANZCO CPD

Evidence of Current Medical Registration is attached

If other please specify

Declaration

20 I declare that:

- I have read the Conditions of Appointment, if designated, I agree to comply with the Conditions. Upon my designation, this declaration shall constitute my acknowledgment for the purposes of subparagraph 4 (xii) and respective authorisation for purposes of subparagraphs 4 (xv) and (xvi) of the Conditions.
- I am authorised to make this application and hold the role indicated below.
- All statements in this application are true and correct in every particular and that I have read and understood all provisions of the Civil Aviation Safety Regulations 1998 which are relevant to this application.
- I understand CASA will use the currently held details to process this application and it is my responsibility to ensure my details are correct prior to lodgement.
- I consent to CASA using and disclosing my personal information in accordance with CASA Privacy Policy including exchanging the information with Commonwealth, State and Territory government agencies.
- I accept that if this application is withdrawn or refused by CASA, or if CASA are unable to assess the application because I have failed to provide the required information, I am liable to pay CASA fees for work conducted.
- I have attached all required documentation specified in the application checklist.
- I acknowledge that to knowingly make a false or misleading statement in this application is an offence against the Criminal Code Act 1995 (Cth).

Full name

Date (DD/MM/YYYY)

/ /

Returning your form



By email (preferred option) – attach this form and all supporting documents.

Send them to dame.liaison@casa.gov.au



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

CASA Aviation Medicine

GPO Box 1544

Canberra City ACT 2601

Alternatively fax completed form to (02) 6217 1640.