

# FIREARM LICENSING AUTHORITY

## Medical Certificate



The Applicant (full name) \_\_\_\_\_

Of (Address) \_\_\_\_\_

has informed me that he/she is in the process of applying to the Firearm Licensing Authority for the grant of a Firearm Licence Certificate Permit or the recertification of a Firearm Licence Certificate Permit Approved Firearm Trainer Status

I have personally examined the Applicant and attest to the accuracy of the information provided below. In view of the enormous mental and physical responsibilities that will be placed on the applicant if the Application is granted, I fully understand and accept that erroneous information knowingly provided or relevant information knowingly omitted will result in the Firearm Licensing Authority reserving the right to reject any future reports prepared by me.

<b>Medical Examination</b>
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Is the Applicant a	Regular Patient	Occasional Patient	New Patient
Applicant's Eyesight	Good	Fair	Poor
Comments if any	_____		
_____			
Applicant's Hearing	Good	Fair	Poor
Comments if any	_____		
_____			
Applicant's Mobility	Good	Fair	Poor
Comments if any	_____		
_____			
Applicant's Blood Pressure	Good	Fair	Poor
Comments if any	_____		
_____			
Applicant's Motor Skills	Good	Fair	Poor
Comments if any	_____		
_____			

APPLICANT'S NAME, MEDICAL DOCTOR'S , SIGNATURE AND DATE

Applicant's General

Mental Health            Good            Fair            Poor

Comments if any \_\_\_\_\_  
\_\_\_\_\_

Applicant's Height \_\_\_\_\_ Applicant's Weight \_\_\_\_\_

- a) Is the Applicant prone to fainting spells or dizziness?            Yes    No
- b) Is the Applicant suffering from epilepsy?            Yes    No
- c) Does the Applicant suffer from any debilitating pains or cramps?    Yes    No
- d) Have you prescribed to the Applicant any drugs which may negatively impact on the Applicants ability to protect and use a firearm? \_\_\_\_\_  
\_\_\_\_\_

If yes, state whether the Applicant will be required to take these prescription drugs on a long term or permanent basis \_\_\_\_\_  
\_\_\_\_\_

- f) Is there any other medical condition that may negatively impact on the Applicants ability to protect and use a firearm competently \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Medical Facility	
Address of Medical Facility	
Telephone No of Medical Facility	
Date of Examination	
Name of Medical Doctor	
Signature and Stamp of Medical Doctor	

APPLICANT'S NAME, MEDICAL DOCTOR'S NAME, SIGNATURE AND DATE

### **Procedures**

- 1) Applicant visits registered Medical Doctor with FLA Medical Certificate FLA002.
- 2) Doctor conducts examination of the applicant.
- 3) Doctor completes FLA Medical Certificate FLA002.
- 4) Applicant retains certificate and submits it along with the other supporting documents.