# 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.

**Medical Examination**

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_____

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|---|---|
| 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 |
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**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.