**JETSTAR JAPAN MEDICAL QUESTIONNAIRE**

The purpose of the following questionnaire is to help candidates prepare for the JCAB medical check.

Even if you currently hold a Class 1 Medical issued from a foreign authority, this provides no guarantee that you will be able to pass the JCAB Medical Check. The JCAB medical check will include blood, urine and  hearing tests, eyesight examinations, electrocardiography, brain scan, chest x-ray, etc.

To provide you the best possible chance of passing the JCAB medical check, without needing further re-testing, it is very important that you complete the below questionnaire accurately and when in doubt please include supporting commentary.

Please submit a completed copy of this questionnaire to: Gkpilotrecruitment@jetstar.com

* If you are unable to complete the questionnaire electronically, please print and return a completed scanned PDF copy.

|  |  |
| --- | --- |
| FULL NAME: |  |
| DATE OF BIRTH: |  |
| HEIGHT (Centimeters): |  |
| WEIGHT (Kilograms):  |  |

|  |
| --- |
| 1. Do you have any restrictions on your current Medical Certificate? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 2. Have you ever been refused, delayed or required additional testing for the issue of a Medical Certificate? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 3. Do you wear glasses, contact lenses or other corrective vision devices? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 4. Do you have any forms of allergy or asthma? [ ]  NO / [ ]  YES*If yes, please describe any medication/treatments being used.* |
| 5. Are you currently taking any forms of medication/medicine? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 6. Have you ever been admitted to hospital or undergone any type of surgery? That has required you to report it to your local aviation authority? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 7. Do you have, or had, any heart conditions? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 8. Do you have, or had, any sleep disorders? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 9. Do you have, or had, any digestive disorders? [ ]  NO / [ ]  YES*If yes, please describe*  |
| 10. Is there anything else of importance we should know in relation to your medical history? |

Thank you for completing the questionnaire we will review the information provided and contact you should we require any further details.