

Guide for DCA 153 Medical Form

The DCA 153 Medical Report Form (“the Form”) is used for recording the medical examination findings of applicants for all classes of medical certificates – both initial and renewal examinations.

Applicants for the issue (including initial and renewal application) of medical certificate must undergo a DCA 153 medical examination conducted by a HKCAD Approved Medical Examiner (AME), together with the special examinations and other tests as required.

Applications for medical certificate should be made via the Medical Certificate Module of the Personnel Licensing Information System (PLIS) (<https://plis.cad.gov.hk/>). Detailed procedures can be found in the user guide on the PLIS.

The paper DCA 153 form serves as an alternative means of submission in case the PLIS is unavailable. It can be accessed at <https://www.cad.gov.hk/application/DCA153.pdf>. It is recommended to use computer to complete the paper DCA 153 form.

Applicants should complete Items 1-20 of the Form and provide declaration and consent to release medical information in Item 21 before the medical examination. The instructions for completing these items can be found below.

Instructions for Completing Items 1-21 of the Form

Item	Description	Remarks
-	Medical examination: Initial or Renewal	Mandatory -Tick Initial or Renewal
-	Name of AME	Mandatory -For PLIS, select AME from dropdown menu -For paper DCA 153 form, input AME name according to the current AME list
-	Date of examination	Mandatory -Input date (dd/mm/yyyy)
1	Name and Title Gender Telephone No. HKID/Passport No.	Mandatory -Input surname and other names identical to passport and select title from dropdown menu -Select M or F from dropdown menu -Input telephone number -For paper DCA 153 form, input HKID or passport number
2	Correspondence Address Email	Mandatory -Input current correspondence address -Input email address

Item	Description	Remarks
3	Nationality	Mandatory -Input nationality
4	Date of birth	Mandatory -Input date (dd/mm/yyyy)
5	Age	Mandatory -Auto-populated from item 4
6	Employer (if applicable)	Mandatory -If principal occupation is pilot, then select employer from dropdown menu
7	Occupation	Mandatory -Input principal occupation
8.1	Class of HK Medical Certificate applied for	Mandatory -Select Class 1, Class 2, or Class 3 Class 1: Professional pilot Class 2: Private pilot Class 3: Air traffic controllers and flight information service officers
8.2	Details of HK Licence held or applied for	Mandatory -Select ATPL, CPL, PPL or ATCL
	Expiry Date(s) of last Medical Certificate(s)	Mandatory if renewal -Input date (dd/mm/yyyy)
	Licence Number(s)	Mandatory -Input licence number
	Hours flown since last medical	Mandatory if renewal -Input numerical values
	Total hours flown	-Input numerical values
9	Any aircraft/incident since last medical?	Mandatory if renewal -Including inflight incapacitation event
	YES/NO (if 'Yes', please give details)	-Select Yes or No. If yes, provide further information
	-Date	-Input date (dd/mm/yyyy)
	-Place	-Input alphanumeric values
	-Details	-Input alphanumeric values
10	Last HKCAD Medical Examination Date	Mandatory if renewal -Input date (dd/mm/yyyy)
	Place (If others, please specify)	Mandatory if renewal

Item	Description	Remarks
		-Select region (Hong Kong / United Kingdom / Australia / New Zealand / Malaysia / Others) from dropdown menu -If others, please specify the place
	AME's Name	-Input AME's Name
11	Name and Address of own Medical Practitioner	-Input alphanumeric values
	Telephone number and email of own Medical Practitioner	-Input alphanumeric values
12	List ALL MEDICATIONS CURRENTLY TAKEN whether prescribed by a doctor or over-the-counter. (Please indicate vitamins, supplements and herbal medicines)	-If medications are currently taken, input alphanumeric values in relevant boxes (i.e. Name, Dose, Date started, Purpose, By Whom Prescribed)
13	Do you smoke tobacco?	Mandatory -Select NEVER, YES or NO. If YES or NO is selected, provide further information
	State type, amount & number of years	Mandatory if YES -Input alphanumeric values
	Date stopped	Mandatory if NO -Input date (dd/mm/yyyy) stopped
14	Do you drink alcohol?	Mandatory -Select NEVER, YES or NO. If YES or NO is selected, provide further information
	How many times in the past year have you consumed 5 or more (standard alcohol units) drinks within a day?	Mandatory if YES -Input in alphanumeric values
	In a typical week, how many days of the week do you have an alcoholic drink?	-Input alphanumeric values
	Weekly alcohol intake in units?	-Input alphanumeric values
	Date stopped	Mandatory if NO -Input date (dd/mm/yyyy) stopped
15	Since last medical examination, have you had any illness, accident, admission to hospital or started	Mandatory if renewal -Select YES or NO. If YES, provide further information in Item 20

Item	Description	Remarks
	long term medication? (If 'YES' please describe in Item 20)	
16	<p>Medical History – Have you ever had any of the following? Please tick YES/NO. (If 'YES', describe in the 'Remarks' column)</p> <p>(a) Eye disorders including refractive disorders which are correctable by spectacles or contact lenses, eye surgery including refractive surgery</p> <p>(b) Ear disease or deafness</p> <p>(c) Motion sickness requiring medication</p> <p>(d) Hayfever or allergy</p> <p>(e) Frequent or severe headaches</p> <p>(f) Dizziness, fainting or unconsciousness</p> <p>(g) Epilepsy or fits</p> <p>(h) Head injury or concussion</p> <p>(i) Psychiatric or nervous trouble of any sort</p> <p>(j) Asthma or other lung disorder</p> <p>(k) Heart trouble or high/low blood pressure</p> <p>(l) Anaemia or other blood disorder</p> <p>(m) Stomach, liver or intestinal disorder</p> <p>(n) Diabetes, thyroid or other hormone disease</p> <p>(o) Sugar or protein in urine</p> <p>(p) Kidney stone or blood in the urine</p> <p>(q) Musculo-skeletal disorder</p> <p>(r) Malaria or other tropical disease</p> <p>(s) A positive HIV test</p> <p>(t) Alcohol/substance abuse or related problem(s) (e.g. Driving Under Influence (DUI) Offence)</p> <p>(u) Use of opioids, cannabinoids, sedatives, cocaine, hallucinogens, solvents,</p>	<p>Mandatory for all Items 16(a) to (w)</p> <p>-Tick boxes: YES or NO for Items 16 (a) to (w)</p> <p>-If YES ticked for any item, please elaborate in the 'REMARKS' column or in Item 20</p>

Item	Description	Remarks
	recreational drugs or other psychoactive substances (v) Admission to hospital overnight (w) Any other illness or injury	
17	Have you ever been: Please tick Yes or No. (If 'YES', describe in the 'Remarks' column) (a) Refused life insurance (b) Denied, deferred or delayed in an application or renewal of an aviation medical certificate by any licensing authority (c) Convicted of civil or criminal offence in or outside Hong Kong	Mandatory -Tick boxes: YES or NO for items 17(a) to (c) -If YES ticked for any item, please elaborate in the 'REMARKS' column or in Item 20
18	Do you have a family history of: Please tick YES or NO. (If 'YES', describe in the 'Remarks' column) (a) Heart disease/high blood pressure (b) Blood disorders/cancers (c) Epilepsy/neurological disease (d) Mental illness (e) Diabetes	Mandatory -Tick boxes: YES or NO for Items 18(a) to (e) -If YES ticked for any item, please elaborate in the 'REMARKS' column or in Item 20
19	Females only: Please tick YES or NO. (If 'YES', describe in the 'Remarks' column) (a) Are you pregnant? (b) Have you had a history of gynaecological problems?	Mandatory for females -Tick boxes: YES or NO for Item 19(a) to (b) -If YES ticked for any item, please elaborate in the 'REMARKS' column or in Item 20
20	Remarks	-Select "Initial medical certificate applicant", "Previously reported and no change since" or "Previously reported and with changes (please provide details below)" -If selected Previously reported and with changes, elaborate in the space
21	Declaration and consent	Mandatory -Tick boxes to provide declaration and consent to release medical information -For paper DCA 153 Form, sign under witness of AME