

JUN 04 2002 810653

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINT Form Approved OMB NO. 2120-0034

Form 8500-9 (Rev. 11-15-99) (Category) or FAA Form 8500-9 (Medical/Student Pilot Certificate) Issued.

MEDICAL CERTIFICATE CLASS AND STUDENT PILOT CERTIFICATE

This certifies that (Full name and address):

Date of Birth	Height	Weight	Hair	Eyes	Sex

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations: *501/201/00000*

Date of Examination: _____ Examiner's Designation No. _____

Signature: _____
Typed Name: _____

AIRMAN'S SIGNATURE

1. Application For: Airman Medical Certificate Airman Medical and Student Pilot Certificate

2. Class of Medical Certificate Applied For: 1st 2nd 3rd

3. Last Name: **TALON** First Name: **JEFFREY** Middle Name: **ALAN**

4. Social Security Number: **299-54-7468**

5. Address: **10205 ROBINSON AVE.** Telephone Number: **(216) 883-0709**

Number / Street: **GARFIELD HTS., OHIO** Zip Code: **44125**

City: _____ State / Country: _____

6. Date of Birth: **10 30 1965** 7. Color of Hair: **RED** 8. Color of Eyes: **BROWN** 9. Sex: **M**

Citizenship: **USA**

10. Type of Airman Certificate(s) You Hold: None ATC Specialist Flight Instructor Recreational Airline Transport Flight Engineer Private Other **A&P** Commercial Flight Navigator Student

11. Occupation: **PILOT** 12. Employer: **UNITED AIRLINES**

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? Yes No If yes, give date **10-16-2001**

Total Pilot Time (Civilian Only) 14. To Date: **10,000+** 15. Past 6 months: **ZERO** 16. Date of Last FAA Medical Application: **125-18-2002**

17.a. Do You Currently Use Any Medication (Prescription or Nonprescription)? No Yes (If yes, below list medication(s) used and check appropriate box).

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying? Yes No

18. Medical History - HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING? Answer "yes" or "no" for every condition listed below. In the EXPLANATIONS box below, you may note "PREVIOUSLY REPORTED NO CHANGE" only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition. See Instructions Page

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart or vascular trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Mental disorders of any sort: depression, anxiety, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Military medical discharge
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spell	<input type="checkbox"/>	<input checked="" type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Medical rejection by military service
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Unconsciousness for any reason	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Alcohol dependence or abuse	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rejection for life or health insurance
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eye or vision trouble except glasses	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Suicide attempt	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Admission to hospital
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hay fever or allergy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Motion sickness requiring medication	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Other illness, disability, or surgery
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma or lung disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological disorders: epilepsy, seizures, stroke, paralysis, etc.						

Conviction and/or Administrative Action History - See Instructions Page

v. History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.

w. History of nontraffic conviction(s) (misdemeanors or felonies).

Explanations: See Instructions Page

a. PREVIOUSLY REPORTED NO CHANGE

b. PREVIOUSLY REPORTED NO CHANGE

c. PREVIOUSLY REPORTED NO CHANGE

d. PREVIOUSLY REPORTED NO CHANGE

e. PREVIOUSLY REPORTED NO CHANGE

f. PREVIOUSLY REPORTED NO CHANGE

g. PREVIOUSLY REPORTED NO CHANGE

h. PREVIOUSLY REPORTED NO CHANGE

i. PREVIOUSLY REPORTED NO CHANGE

j. PREVIOUSLY REPORTED NO CHANGE

k. PREVIOUSLY REPORTED NO CHANGE

l. PREVIOUSLY REPORTED NO CHANGE

m. PREVIOUSLY REPORTED NO CHANGE

n. PREVIOUSLY REPORTED NO CHANGE

o. PREVIOUSLY REPORTED NO CHANGE

p. PREVIOUSLY REPORTED NO CHANGE

q. PREVIOUSLY REPORTED NO CHANGE

r. PREVIOUSLY REPORTED NO CHANGE

s. PREVIOUSLY REPORTED NO CHANGE

t. PREVIOUSLY REPORTED NO CHANGE

u. PREVIOUSLY REPORTED NO CHANGE

v. PREVIOUSLY REPORTED NO CHANGE

w. PREVIOUSLY REPORTED NO CHANGE

x. PREVIOUSLY REPORTED NO CHANGE

USA 1 - USA 13 ARE ATTACHED

FOR FAA USE Review Action Codes

19. Visits to Health Professional Within Last 3 Years. Yes (Explain Below) No See Instructions Page

Date	Name, Address, and Type of Health Professional Consulted	Reason
04-03-02	DR. BARTON PAKULL FAA WASHINGTON	WRITTEN REPORT ATTACHED
04-03-02	DR. POOLE FAA WASHINGTON	FAA CERTIFICATION
10-16-02	DR. JON L. JORDAN FEDERAL AIR SURGEON	MYOFASCIAL PAIN SYNDROME

20. Applicant's National Driver Register and Certifying Declarations

I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S. Code 401, Note.

NOTE: ALL persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.

I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.

Signature of Applicant: *Jeffrey A. Talon* Date: **125-18-2002**