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

Copy of FAA Form 8500-9 (Medical Certificate) or FAA Form 8420-2 (Medical/Student Pilot Certificate) issued.

MEDICAL CERTIFICATE THIRD CLASS AND STUDENT PILOT CERTIFICATE

This certifies that ***(Full name and address):***

BRENNAN Cordero GILES
1375 sw a Avenue #111
Corvallis, OR 97333

Date of Birth	Height	Weight	Hair	Eyes	Sex
06/28/1996			BROWN	BROWN	M

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

Limitations

Date of Examination | Examiner's Designation No.

Examiner: Signature / Typed Name

AIRMAN'S SIGNATURE

1. Application For: [X] Airman Medical Certificate [ ] Airman Medical and Student Pilot Certificate

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

3. Last Name GILES **First Name** BRENNAN **Middle Name** Cordero

4. Social Security Number 541-49-9048

5. Address 1375 sw a Avenue #111 Telephone Number (503) 515-9810
Number / Street
Corvallis OR 97333
City State / Country Zip Code

6. Date of Birth 06/28/1996 (MM/DD/YYYY) **Citizenship** USA
7. Color of Hair BROWN
8. Color of Eyes BROWN
9. Sex Male

10. Type of Airman Certificate(s) You Hold:
[X] None [ ] ATC Specialist [ ] Flight Instructor [ ] Recreational
[ ] Airline Transport [ ] Flight Engineer [ ] Private [ ] Other
[ ] Commercial [ ] Flight Navigator [ ] Student

11. Occupation Student
12. Employer None

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked?
[ ] Yes [X] No If yes, give date ____ (MM / DD / YYYY)

Total Pilot Time (Civilian Only)
14. To Date 0
15. Past 6 months 0

16. Date of Last FAA Medical Application ____ (MM/DD/YYYY) [X] **No Prior Application**

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

	Previously Reported Yes	No
	[ ]	[ ]
	[ ]	[ ]
	[ ]	[ ]

(If more space is required, see 17. a. on the instruction sheet).

17.b. Do You Ever Use Near Vision Contact Lens(es) While Flying? [ ] **Yes** [X] **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
a. [ ]	[X]	Frequent or severe headaches	g. [ ]	[X]	Heart or vascular trouble	m. [ ]	[X]	Mental disorders of any sort; depression, anxiety, etc.	r. [ ]	[X]	Military medical discharge
b. [ ]	[X]	Dizziness or fainting spell	h. [ ]	[X]	High or low blood pressure	n. [ ]	[X]	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 2 years.	s. [ ]	[X]	Medical rejection by military service
c. [ ]	[X]	Unconsciousness for any reason	i. [ ]	[X]	Stomach, liver, or intestinal trouble				t. [ ]	[X]	Rejection for life or health insurance
d. [ ]	[X]	Eye or vision trouble except glasses	j. [ ]	[X]	Kidney stone or blood in urine	o. [ ]	[X]	Alcohol dependence or abuse	u. [ ]	[X]	Admission to hospital
e. [X]	[ ]	Hay fever or allergy	k. [ ]	[X]	Diabetes	p. [ ]	[X]	Suicide attempt	x. [ ]	[X]	Other illness, disability, or surgery
f. [ ]	[X]	Asthma or lung disease	l. [ ]	[X]	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	q. [ ]	[X]	Motion sickness requiring medication	y. [ ]	[X]	Medical disability benefits

Arrest, Conviction, and/or Administrative Action History --- See Instructions Page

Yes	No		Yes	No	
v. [ ]	[X]	History of (1) any arrest(s) and/or 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 arrest(s), and/or conviction(s), and/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. [ ]	[X]	History of nontraffic conviction(s) (misdemeanors or felonies).

Explanations: **See Instructions Page**

See Form 8500-8 Continuation Sheet for Comments

FOR FAA USE Review Action Codes

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

Date	Name, Address, and Type of Health Professional Consulted	Reason

-- NOTICE --
Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willingly falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Secs. 1001; 3571).

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 | Date 10/10/2018 11:37:14 pm (MM/DD/YYYY)

Form 8500-8 Continuation Sheet

17.a. Medications (From page 1):

Medication	Previously Reported	
	Yes	No

18. Explanations (From page 1):

18E Moderate allergies during spring lasting about 2 weeks.

19. Visits to Health Professional Within Last 3 Years. (From page 1):

Date Form Submitted: 10/10/2018 11:37:14 pm

IP Address Form Submitted From: 73.67.204.151

Confirmation Number: 54431003504