

MEDICAL CERTIFICATE SECOND CLASS

This certifies that (Full name and address):

CLEMENT LE BRUN
17 B AVENUE DE TREBEHORET
PONT L ABBE 29120 France

Date of Birth	Height	Weight	Hair	Eyes	Sex
11/12/1989	73	187	BROWN	BROWN	M

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

Limitations	None

Date of Examination	Examiner's Designation No.
10/31/2014	15817

Examiner	Signature
	Typed Name JEAN GEORGES MOUCHARD, MD

AIRMAN'S SIGNATURE

Applicant ID: 2001895823	Control No.: 200006670184
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FAA Form 8500-9 (9-08) Supersedes Previous Edition NSN: 0052-00-670-7002

(Cut on dashed line)

CONDITIONS OF ISSUE

The holder of this certificate must:

- Have it in his or her personal possession at all times while exercising privileges of an airman certificate. (14CFR § 61.3)
- Understand that the issuance of a medical certificate by an Aviation Medical Examiner may be reversed by the FAA within 60 days. (14CFR § 67.407)
- Comply with validity standards specified for first-, second-, and third-class medical certificates. (14CFR § 61.23)
- Comply with any statement of functional, operational, and/or time limitation issued as a condition of certification. (14CFR § 67.401)
(Note: A letter of authorization (or SODA) describing any such limitations must be kept with this certificate at all times while exercising the privileges of an airman certificate.)
- Comply with the standards relating to prohibitions on operation during medical deficiency. (14CFR §§ 61.53, 63.19, and 65.49)

For International Operations Only: Some holders may be affected by certain international medical standards. Consult the U.S. Aeronautical Information Publication for U.S. differences with ICAO Annex 1 medical standards.



AEROSPACE MEDICAL CERTIFICATION DIVISION, AAM - 300
FAA Civil Aerospace Medical Institute
Mike Monroney Aeronautical Center
P.O Box 26080
Oklahoma City, OK 73125-9914

CLEMENT LE BRUN
17 B AVENUE DE TREBEHORET
PONT L ABBE 29120 France

Dear Airman:

Above is your new medical certificate. It supersedes any previous one you may have been issued.

To validate this certificate, it is necessary that you sign it in the space provided (Airman's Signature).

This certificate must be in your possession at all times while exercising your pilot privileges.

Applicant Must Complete ALL 20 Items (Except For Shaded Areas) PLEASE PRINTCopy of FAA Form 8500-9
(Medical Certificate) or FAA
Form 8420-2 (Medical/Student
Pilot Certificate) Issued.**GG-****MEDICAL CERTIFICATE
AND STUDENT PILOT CERTIFICATE****This certifies that(Full name and address):**CLEMENT LE BRUN
17 B AVENUE DE TREBEHORET
PONT L ABBE, 29120

Date of Birth	Height	Weight	Hair	Eyes	Sex
11/12/1989			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.

Signature

Typed Name

AIRMAN'S SIGNATURE**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. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Frequent or severe headaches	g. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart or vascular trouble	m. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.	r. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Military medical discharge
b. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness or fainting spell	h. <input type="checkbox"/>	<input checked="" type="checkbox"/>	High or low blood pressure	n. <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.	s. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Medical rejection by military service
c. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Unconsciousness for any reason	i. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Stomach, liver, or intestinal trouble	o. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Alcohol dependence or abuse	t. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Rejection for life or health insurance
d. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Eye or vision trouble except glasses	j. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney stone or blood in urine	p. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Suicide attempt	u. <input checked="" type="checkbox"/>	<input type="checkbox"/>	Admission to hospital
e. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Hay fever or allergy	k. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	q. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Motion sickness requiring medication	x. <input checked="" type="checkbox"/>	<input type="checkbox"/>	Other illness, disability, or surgery
f. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma or lung disease	l. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	y. <input type="checkbox"/>	<input checked="" type="checkbox"/>	Medical disability benefits			

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

Yes	No	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.	Yes	No	History of nontraffic conviction(s) (misdemeanors or felonies).
v. <input type="checkbox"/>	<input checked="" type="checkbox"/>		w. <input type="checkbox"/>	<input checked="" type="checkbox"/>	

Explanations: See Instructions Page

18u - Admission to hospital for minor surgery; 18x - Cyst removal surgery;

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
1/15/2014	DR MOUCHARD TOULOUSE AIRPORT TOULOUSE, 31000 PHYSICIAN	FAA CLASS 2 MEDICAL

- NOTICE -

Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully 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 10/29/2014

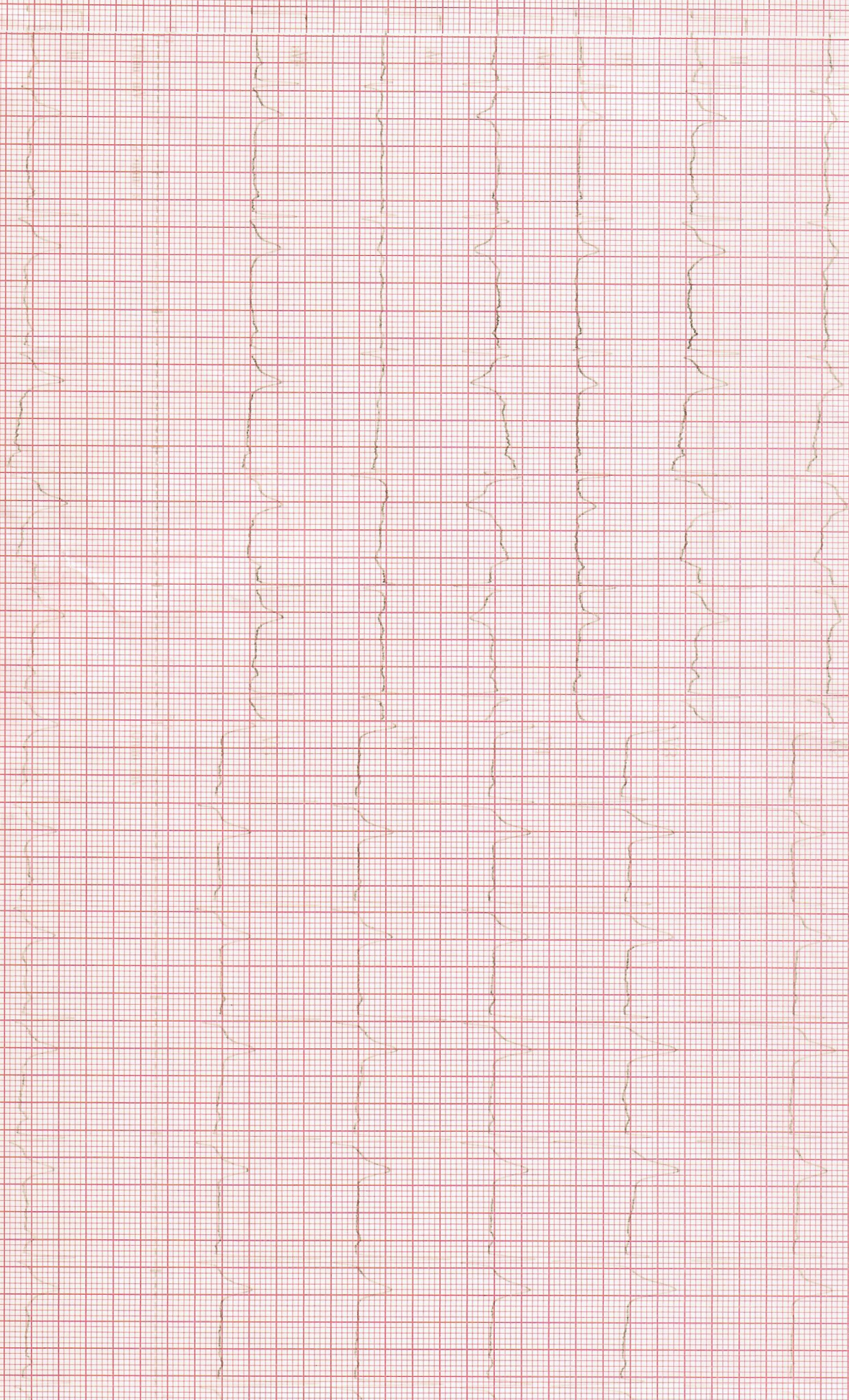
LE BRUN LOUPOT

Clément

Né le: 12/11/1989

À: QUIMPER (29)

12210



NOTE: FAA/Original Copy of the Report of Medical Examination Must be TYPED.

REPORT OF MEDICAL EXAMINATION

21. Height (inches) <u>73</u>	22. Weight (pounds) <u>187</u>	23. Statement of Demonstrated Ability (SODA) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Defect Noted:	24. SODA Serial Number				
CHECK EACH ITEM IN APPROPRIATE COLUMN		Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN		Normal	Abnormal
25. Head, face, neck, and scalp		<input checked="" type="checkbox"/>		37. Vascular system (Pulse, amplitude and character; arms, legs, others)		<input checked="" type="checkbox"/>	
26. Nose		<input checked="" type="checkbox"/>		38. Abdomen and viscera (Including hernia)		<input checked="" type="checkbox"/>	
27. Sinuses		<input checked="" type="checkbox"/>		39. Anus (Not including digital examination)		<input checked="" type="checkbox"/>	
28. Mouth and throat		<input checked="" type="checkbox"/>		40. Skin		<input checked="" type="checkbox"/>	
29. Ears, general (Internal and external canals; Hearing under item 49)		<input checked="" type="checkbox"/>		41. G-U system (Not including pelvic examination)		<input checked="" type="checkbox"/>	
30. Ear Drums (Perforation)		<input checked="" type="checkbox"/>		42. Upper and lower extremities (Strength and range of motion)		<input checked="" type="checkbox"/>	
31. Eyes, general (Vision under items 50 to 54)		<input checked="" type="checkbox"/>		43. Spine, other musculoskeletal		<input checked="" type="checkbox"/>	
32. Ophthalmoscopic		<input checked="" type="checkbox"/>		44. Identifying body marks, scars, tattoos (Size & location)		<input checked="" type="checkbox"/>	
33. Pupils (Equality and reaction)		<input checked="" type="checkbox"/>		45. Lymphatics		<input checked="" type="checkbox"/>	
34. Ocular motility (Associated parallel movement, nystagmus)		<input checked="" type="checkbox"/>		46. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)		<input checked="" type="checkbox"/>	
35. Lungs and chest (Not including breast examination)		<input checked="" type="checkbox"/>		47. Psychiatric (Appearance, behavior, mood, communication, and memory)		<input checked="" type="checkbox"/>	
36. Heart (Precordial activity, rhythm, sounds, and murmurs)		<input checked="" type="checkbox"/>		48. General systemic		<input checked="" type="checkbox"/>	

NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

LE BRUN LOUPOT

Clément

Né le: 12/11/1989

12210

À: QUIMPER (29)

19. Hearing		Record Audiometric Speech Discrimination Score Below	Right Ear					Left Ear				
Conversational Voice Test at 6 Feet		Audiometer Threshold in decibels	500	1000	2000	3000	4000	500	1000	2000	3000	4000
<input checked="" type="checkbox"/> Pass <input type="checkbox"/> Fail			<u>10</u>	<u>10</u>	<u>5</u>	<u>10</u>	<u>5</u>	<u>10</u>	<u>10</u>	<u>5</u>	<u>5</u>	<u>5</u>
20. Distant Vision		51.a. Near Vision		51.b. Intermediate Vision - 32 Inches				52. Color Vision				
Right 20/20	Corrected to 20/	Right 20/20	Corrected to 20/	Right 20/	Corrected to 20/			<input checked="" type="checkbox"/> Pass				
Left 20/20	Corrected to 20/	Left 20/20	Corrected to 20/	Left 20/	Corrected to 20/			<input type="checkbox"/> Fail				
Both 20/20	Corrected to 20/	Both 20/20	Corrected to 20/	Both 20/	Corrected to 20/							
23. Field of Vision		54. Heterophoria 20' (in prism diopters)		Esophoria		Exophoria		Right Hyperphoria		Left Hyperphoria		
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal				<u>0</u>		<u>0</u>		<u>0</u>		<u>0</u>		
25. Blood Pressure		56. Pulse (Resting)		57. Urine Test (if abnormal, give results)				58. ECG (Date)				
Systolic Diastolic		20		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal				M M D D Y Y Y Y				
Sitting, mm of Mercury		<u>160 / 80</u>										
29. Other Tests Given												

0. Comments on History and Findings: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.)

FOR FAA USE

Pathology Codes:

Coded By:

Clerical Reject

Significant Medical History <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Abnormal Physical Findings <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
1. Applicant's Name		62. Has Been Issued — <input checked="" type="checkbox"/> Medical Certificate <input type="checkbox"/> Medical & Student Pilot Certificate <input type="checkbox"/> No Certificate Issued — Deferred for Further Evaluation <input type="checkbox"/> Has Been Denied — Letter of Denial Issued (Copy Attached)	
3. Disqualifying Defects (List by item number)			
4. Medical Examiner's Declaration — I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.			
Date of Examination		Aviation Medical Examiner's Name	
M M D D Y Y Y Y		Street Address	
		City State Zip Code	
		AME Serial Number	
		AME Telephone ()	