UNITED STATES OF AMERICA
Department of Transportation
Federal Aviation Administration

MEDICAL CERTIFICATE FIRST CLASS

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

CASIMIR MROZOWSKI
19 Reynolds Ave
Beeton L0G1A0 Canada

Date of Birth	Height	Weight	Hair	Eyes	Sex
08/16/1994	72	168	BROWN	GREEN	M

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

Limitations

Valid for 12 months following the month examined.

Examiner

Date of Examination: 06/30/2021

Examiner's Designation No.: 000000773

Signature

Typed Name: PATRICK CORREA, MD

Dr Patrick ... Medecine Aeronautique MD/004/ANACS/DTA/08 DGAC N°3857.

AIRMAN'S SIGNATURE

Applicant ID: 2001845789

Control No.: 200009606929

FAA Form 8500-9 (3-12) Supersedes Previous Edition

NSN: 0052-00-670-7002

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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)
- 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.

(Cut on dashed line)

Aviation Safety
Office of Aerospace Medicine
Aerospace Medical Certification Division, AAM-300
P.O. Box 25082
Oklahoma City, OK 73125-9867

CASIMIR MROZOWSKI
19 Reynolds Ave
Beeton L0G1A0 Canada

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 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 FIRST CLASS AND STUDENT PILOT CERTIFICATE

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

CASIMIR MROZOWSKI
19 Reynolds Ave
Beeton, L0G1A0

Date of Birth	Height	Weight	Hair	Eyes	Sex
08/16/1994			BROWN	GREEN	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: [X] 1st [ ] 2nd [ ] 3rd

3. Last Name MROZOWSKI **First Name** CASIMIR **Middle Name**

4. Social Security Number 164-37-2521

5. Address 19 Reynolds Ave (Number / Street) Telephone Number (306) 420-0654
Beeton (City) Canada (State / Country) L0G1A0 (Zip Code)

6. Date of Birth 08/16/1994 (MM/DD/YYYY) **Citizenship** France | **7. Color of Hair** BROWN | **8. Color of Eyes** GREEN | **9. Sex** Male

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

11. Occupation Pilot | **12. Employer** UMS

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 3500 | **15. Past 6 months** 400

16. Date of Last FAA Medical Application 06/05/2020 (MM/DD/YYYY) [ ] 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

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 06/29/2021 12:40:28 pm (MM/DD/YYYY)

Confirmation Number: 979343263534

Form 8500-8 Continuation Sheet

17.a. Medications (From page 1):

Medication	Previously Reported	
	Yes	No

18. Explanations (From page 1):

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

Date Form Submitted: 06/29/2021 12:40:28 pm

IP Address Form Submitted From: 41.223.48.206

Confirmation Number: 979343263534

DR SINCOX (704) 730-9065

UNITED STATES OF AMERICA
Department of Transportation
Federal Aviation Administration

MEDICAL CERTIFICATE FIRST CLASS

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

CASIMIR MROZOWSKI
19 Reynolds Ave
Beeton L0G1A0 Canada

Date of Birth	Height	Weight	Hair	Eyes	Sex
08/16/1994	72	160	BROWN	GREEN	M

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

Limitations: None

Date of Examination: 06/05/2020
Examiner's Designation No.: 000008920

Examiner
Signature: [signature] M.D
Typed Name: FRANCIS SINCOX Jr MD

AIRMAN'S SIGNATURE [signature]

Applicant ID: 2001845789
Control No.: 200009120023

FAA Form 8500-9 (3-12) Supersedes Previous Edition NSN: 0052-00-670-7002

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CONDITIONS OF ISSUE

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Aviation Safety
Office of Aerospace Medicine
Aerospace Medical Certification Division, AAM-300
P.O. Box 25082
Oklahoma City, OK 73125-9867

CASIMIR MROZOWSKI
19 Reynolds Ave
Beeton L0G1A0 Canada

888-16-1349

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.

Created on Friday, June 5, 2020

Page réservée aux autorités compétentes
pour délivrer le passeport
Página reservada a las autoridades competentes
para expedir el pasaporte / Forbeholdt de pasudstedende
myndigheder / Amtliche Vermerke
Προορίζεται για τις αρχές που είναι αρμόδιες για την
έκδοση του διαβατηρίου / Page reserved for issuing authorities
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Opmerkingen van bevoegde instanties
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para emitir o passaporte / Varattu passinantoviranomaisille
Förbehållet utlämnande myndighet.

08

Ce passeport contient un composant électronique.
Il convient d'en prendre soin, et en particulier
de ne pas le plier, le perforer, l'exposer à des températures
extrêmes ou à une humidité excessive.

This passport contains sensitive electronics.
For best performance please do not bend,
perforate or expose to extreme temperatures
or excess moisture.

Signature du titulaire/*Holder's signature*

RÉPUBLIQUE FRANÇAISE

PASSEPORT
PASSPORT

Type / Code du pays / Passeport n°
P FRA 14DY70660

Nom / Surname (1)
MROZOWSKI

Prénoms
Casimir

Nationalité / Nationality
Française

Sexe / Sex (3) M

Taille / Height (4) 1,80 m

Couleur des yeux / Colour of eyes (5) VERTE

Date de naissance / Date of birth (6)
16 08 1994

Lieu de naissance / Place of birth (6)
PARIS 12E ARRONDISSEMENT

Date de délivrance / Date of issue
05 02 2015

Autorité / Authority (9)
MIAMI-
CONSULAT GENERAL DE FRANCE

Domicile / Residence (11)
2532 MONTCLAIRE CIR
WESTON, FL 33327
ÉTATS UNIS

Date d'expiration / Date of expiry (8)
04 02 2025

P<FRAMROZOWSKI<<CASIMIR<<<<<<<<<<<<<<<<<<<<<<
14DY706601FRA9408160M2502047<<<<<<<<<<<<<<04

Agence Nationale de l'Aviation Civile et de la Météorologie	FORMULAIRE	SN-SEC-MED-FORM-02-A	
	RAPPORT D'EXAMEN MEDICAL	Date d'application : 10/06/2017	Page 1 sur 2

NOM : MROZOWSKI		Prénoms : CASIMIR			Date de naissance (JJ/MM/AAAA): 16/08/1994 Lieu de naissance : PARIS, FRANCE		
(201) Catégorie d'examen ☐ Initial ☐ Prorogation ☐ Renouvellement ☐ Recours spécial	(202) Taille 183 cm 72 - 168,5	(203) Poids 76 kg	(204) Yeux couleur	(205) Cheveux couleur	(206) Tension artérielle (assis) mmHg		(207) Pouls au repos
					Systolique	Diastolique	Pulsations / Rythme
					110	60	57 / ☐ irrégulier ☑ régulier

Examen clinique : Cochez chaque item	normal	anormal		normal	anormal
(208) Tête, face, cou, cuir chevelu	✓		(218) Abdomen, hernie, foie, rate	✓	
(209) Cavité bucale, gorge, dents	✓		(219) Anus, rectum (si nécessaire)		
(210) Nez, sinus	✓		(220) système génito-urinaire	✓	
(211) Oreilles, tympans, compliance tympanique	✓		(221) Système endocrinien, thyroïde	✓	
(212) Yeux- orbites et annexes, champs visuels	✓		(222) Membres supérieurs et inférieurs, articulations	✓	
(213) Yeux - pupilles	✓		(223) Colonne vertébrale et appareil musculosquelettique	✓	
(214) Yeux - mobilité oculaire, nystagmus	✓		(224) Examen neurologique- réflexes etc	✓	
(215) Poumons, thorax, seins	✓		(225) Psychiatrie	✓	
(216) Cœur	✓		(226) Peau, marque d'identification, syst. lymphatique	✓	
(217) Système vasculaire	✓		(227) Etat général	✓	

(228) Notes : Décrivez chaque anomalie constatée. Reportez le numéro de l'item avant chaque commentaire

Mongolot. BV. 90 - 900 - 350 26 ans. Tabac = 0 Alcool [illegible]
Celib [illegible]. / Stress. Sport = 0.

Acuité visuelle (ne pas remplir ici lors des examens approfondis)

(229) (de loin à 5m/6m en dixième			Lunettes/Contact
Œil droit sans correction	10	Corrigée à	
Œil gauche sans correction	10	Corrigée à	
Vision binoculaire, sans correction	10	Corrigée à	

(230) **Vision intermédiaire**	Sans correction		Avec correction	
N14 lu à 100cm	Oui	Non	Oui	Non
Œil droit	✓			
Œil gauche	✓			
Vison binoculaire	✓			

(235)Analyse d'urine Normale ☒ anormale ☐

Glucose	Protéines	Sang	Autres
0	0	0	

Rapport annexés	Non réalisé	Date	Normal	Anormal
(238)ECG			✓	
(239) Audiogramme			✓	
(240) Examen Ophtalmologique				
(241) Examen ORL				
(242) Lipides sanguins				
(243) Fonctions respiratoires				
(320) Tonométrie G : D : mmHg				

Agence Nationale de l'Aviation Civile et de la Météorologie	FORMULAIRE	SN-SEC-MED-FORM-02-A	
	RAPPORT D'EXAMEN MEDICAL	Date d'application : 10/06/2017	Page 2 sur 2

(231) **de près**	Sans correction		Avec correction	
N5 lu à 30 – 50cm	Oui	Non	Oui	Non
Œil droit				
Œil gauche				
Vison binoculaire				

(232) **Lunettes**		(233) **Lentilles de contact**	
Oui □	Non □	Oui □	Non □
Type :		Type :	

réfraction	Sph	Cylindre	Axe	Ajouter
		OD.	7 exo 4.	
		OG.	4 exo 4.	

(313) **Perception des couleurs** Normale □ Anormale □

Tables pseudo-isochromatiques Nombre de tables présentées	20	Type ISHIHARA Nombre d'erreurs	0

(234) **Audition** (ne pas remplir ici lors des examens approfondis (si 239/241 non réalisé

	Oreille droite	Oreille gauche
Test de voix de conversation perçue à 2m le dos tourné vers l'examinateur	Oui ☑ Non □	Oui ☑ Non □

Audiométrie éventuelle

Hz	500	1000	2000	3000	4000	6000
Oreille droite						
Oreille gauche						

(236) **Fonction respiratoire** (237) Hémoglobine

Glycémie - 76 mg/dl

VEMS/CV %		Peack Flow (l/min)		(g/dl)	
Normal □	Anormal □	Normal □	Anormal □	Normal ☑ 16,4	Anormal □

(244) Divers (Sujet ?)	□		□	□

(247) Nom et signature du médecin examinateur de médecine générale dans l'AeMC et sa proposition d'aptitude

Avis :	Nom : Signature :

(247 bis) Décision du médecin-chef de l'AeMC ou du médecin agréé

□**APTE pour la classe :**
□**INAPTE pour la classe :**
□**Remis pour une évaluation complémentaire**
dans l'affirmative, indiquer :
Le destinataire :
Le motif :

Renvoi/Concertation
Si une décision a été prise antérieurement par l'autorité en inscrire ici les références et le libellé complet et les reporter sur le certificat d'aptitude remis au candidat.
Décision n° ..... Du .....
Libellé :

Champ d'application du certificat	**Classe 1** □	**Classe 2** □	**Classe 3** □

(248) **commentaires, limitations** :

(249) **Déclaration du médecin chef ou du médecin agréé**

Je soussigne certifie que j'ai personnellement examiné le demandeur mentionné ci-dessus et que ce rapport d'examen médical et ses annexes contiennent mes constatations d'une manière complète.

(250) Lieu et date	Nom et adresse du médecin agrée	Cachet et signature