

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):
 JOSE CARLOS COUTINHO VITORIA SOULE
 102 Torrey Ave
 Brockton, MA 02301-4844

Date of Birth	Height	Weight	Hair	Eyes	Sex
09/03/1981			BLACK	BROWN	M

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

COPY

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 COUTINHO VITORIA SOULE **First Name** JOSE CARLOS **Middle Name**

4. Social Security Number 980-14-6466

5. Address 102 Torrey Ave **Telephone Number** (508) 513-7000
 Brockton MA 02301-4844
 City State / Country Zip Code

6. Date of Birth 09/03/1981 **7. Color of Hair** BLACK **8. Color of Eyes** BROWN **9. Sex** Male
 Citizenship Portugal

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

11. Occupation Pilot **12. Employer**

13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked?
 Yes No If yes, give date _____

Total Pilot Time (Civilian Only) **16. Date of Last FAA Medical Application**
14. To Date 9816 **15. Past 6 months** 195 10/07/2016 No Prior Application
 MM/DD/YYYY

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

	Yes	No
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

(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 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 type="checkbox"/>	<input checked="" type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart or vascular trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental disorders of any sort; depression, anxiety, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Military medical discharge
<input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Medical disability benefits

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

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

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

-- 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: 02/25/2026 06:27:19 am
 MM/DD/YYYY

Form 8500-8 Continuation Sheet

17.a. Medications (From page 1):

Previously Reported

Medication

Yes No

18. Explanations (From page 1):

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

Date Form Submitted: 02/25/2026 06:27:19 am

IP Address Form Submitted From: 23.205.108.9