

**U.S. DEPARTMENT OF TRANSPORTATION  
Federal Aviation Administration**

**REQUEST FOR COPIES OF AIRMAN MEDICAL FILE  
UNDER THE FREEDOM OF INFORMATION ACT**

**PRIVACY ACT:** This information is required under the authority of Transportation Title 49 U.S.C. Section 4753 et. seq. Your request cannot be processed unless the data below is complete. Disclosure of your date of birth (DOB) or Social Security Number is optional. Refusal to furnish your DOB or Social Security Number will not result in the denial of any right, benefit, or privilege provided by law; however, failure to provide your DOB or SSN may result in the delay of a response or the processing of your inquiry.

PLEASE PRINT (excluding signature below)

|  |                               |                             |
|--|-------------------------------|-----------------------------|
| <b>Last</b>  | <b>First</b>                  | <b>Middle</b>               |
| <b>Full Name (as it appears on your medical certificate)</b> |                               |                             |
| <b>DOB (MMDD/YYYY)</b>                                       | <b>Social Security Number</b> | <b>US Citizen Yes or No</b> |
| <b>FAA Medical Reference Number (APP ID, MID #)</b>          |                               |                             |

**Current Mailing Address: Street Address, Apt./Suite No., PO Box/Rural Route No.**

|             |              |                 |
|-------------|--------------|-----------------|
| <b>City</b> | <b>State</b> | <b>Zip Code</b> |
|-------------|--------------|-----------------|

There may be a fee for copies. If the cost is \$20.00 or more the requester will be notified and asked for concurrence to pay in written form (fax, e-mail or postal service).

**Statement Under Perjury:** I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than \$10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than \$5,000.

**Please check the appropriate box for the records you would like to obtain.**

|  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Airman Medical File | <input type="checkbox"/> Non Certified Copy | <input type="checkbox"/> Airman Medical File to Third Party | <input type="checkbox"/> Non Certified Copy |
| <input type="checkbox"/> Certified Copy      |   | <input type="checkbox"/> Certified Copy                     |   |

I authorize the Federal Aviation Administration to release copies of my airman medical records to the person(s) or companies listed below:

Hoosier Services Inc.

**Third Party Name**

18032 Lemon Dr., #C-618

Phone: 800.882.4156 Fax: 800.882.4957

**Mailing Address: Street Address, Apt./Suite No., PO Box/Rural Route No. email: service@hoosierservicesinc.com**

Yorba Linda

CA

92886

**City**

**State**

**Code**

**Mail this request to:**

**Federal Aviation Administration  
Aerospace Medical Certification Division,  
FOIA OFFICE AAM-6 ROOM 223  
CAMI, Building 13  
PO Box 25082  
Oklahoma City, OK 73125-9867**

**Fax #**

**405-954-5912**

**Signature (Typed or printed signature is not acceptable.)**

**Date**