**Personal data protection information can be found on:** [**https://www.caa.bg/bg/category/747/8879**](https://www.caa.bg/bg/category/747/8879)

*The form should be completed in block capitals using black or blue ink.*

**Please note**: *Only English Language accepted: (Any charges incurred for translations are the responsibility of the Applicant)*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *TO BE COMPLETED BY APPLICANT* | | | | | | | | | | |
| State of Transfer FROM:  (*Country and Authority)*  State of Transfer TO:  (*Country and Authority)* |  | | | | | | | | | |
|  | | | | | | | | | |
| *Full name of the applicant* |  | | | | | | | | | |
| *Date of birth (dd/mm/yyyy)* |  | | | | *Nationality* | | | | |  |
| *Address of the applicant* |  | | | | | | | | | |
| *Contact details* | *e-mail* | |  | | | *Phone number* | |  | | |
| *Licence(s) Held* | *Type:*  *(ATPL/CPL/PPL)* | |  | | | *Reference No.* | |  | | |
| *Restriction or Limitations (if any)* |  | | | | | | | | | |
| ***MEDICAL CERTIFICATE*** | | | | | | | | | | |
| *Reference No.* | | *Class* | | *Initial medical certificate (year)* | | | *Validity of current medical certificate (dd/mm/yyyy)* | | | |
|  | |  | |  | | |  | | | |
| I hereby declare that:   * I apply for a change of my current competent authority and to that end, I consent to a transfer of medical records, including the transfer of medical records and associated exchange of information between the current and future competent authorities; * I am not holding any medical certificate in the same category issued by another Member State; * I have not applied for any medical certificate with the same scope and the same category in another Member State; * I have never held any medical certificate in the same category issued in another Member State, which was revoked or suspended in any other Member State; * I have not submitted any other request to another competent authority than the future competent authority as indicated above; * I authorize and give my consent to transfer my aero-medical records (forms and attachments) between the Licencing Authority Aero-Medical Sections / Medical assessors, in paper or electronic format, recognizing that these data are to be used for a licence transfer and medical confidentiality will be respected at all times.   ***I declare that the information provided on this application form is true, complete, and correct.***  ***Any incorrect information in this form or non-compliance with the essential requirements of Annex IV to the Basic Regulation or with the requirements of Regulation EU No 1178/2011, EU 2018/395 and EU 2018/1976 could disqualify me as applicant from having my records transferred from the current to the future competent authority.*** | | | | | | | | | | |
| *Name and signature of the applicant:* | | | | | | | | | *Date:* | |