Federal Aviation Administration

# Current Status Report

XXX Region
Aerospace Medical Division
Address
City, State Zip
Phone
Fax

**PLEASE MAIL OR FAX USING THE INFORMATION ABOVE**

**Part 1: Instruction to FAA Employee**

**To: _____ Facility: _____ Date of Request: _____**
To further assess your medical qualifications to perform the duties of an Air Traffic Control Specialist (ATCS), please have your attending physician complete Part 2 below concerning your medical condition.

(Type further instruction to employee here)

XXXXXXXXXXXXXX.
Flight Surgeon

**Part 2: Instruction to Doctor**
The following information should be taken from the patient's records. The FAA will not be financially responsible for additional testing. Please include ***all*** current medications and comments about any side-effects the patient has experienced.

**Due Date: _____**

**MEDICAL HISTORY:** ***(past med hx, symptoms, durations, dates)*** _____

**PHYSICAL FINDINGS and PERTINENT VITAL SIGNS:** ***(Include results of any tests and xrays previously taken)*** _____

**TREATMENT:** ***(Include surgeries, & ALL medications with dosages, side effects, date started, & date discontinued)*** _____

**DIAGNOSIS/ICD9 CODES/PROGNOSIS:** ***(Include work restrictions and limitations if any)*** _____

**Printed Physician's Name, Address, Telephone Number:** _____

**Doctor's Signature _____ Date _____**