Upcoming CAMA Meeting Focuses on Quality Exams and the Era of BasicMed

Quality of exams and review of commonly encountered clinical conditions will be the mainstay of this year’s CAMA Annual Scientific and Educational Meeting scheduled for September 14-16 in Greensboro, North Carolina. The meeting will also review the early experience of BasicMed, including the numbers of pilots who have elected to utilize the alternative to medical certification and how the program has been accepted in the AME, pilot, and primary care physician communities.

CAMA Vice-president for Education, Dr. Robert Haddon, has coordinated a lineup of experienced faculty from multiple disciplines, including some of whom are well known to CAMA audiences, and others who have been invited to speak on the basis of specialized expertise.

“The strength of CAMA’s programming is its education,” explained CAMA President Clayton T. Cowl, MD, MS. “This fall our attendees will walk away with CME and MOC but more importantly, the opportunity to pick up some practical tools that they can implement in their practices.”

We have requested 22.50 hours of CME for this year’s event from AAFP. Networking events will include a tour of the local NASCAR museum as well as a static display of new business jets and exotic cars. Registration and hotel reservations are available at www.civilavmed.org with rates increasing after August 14.

FAA working to address backlog of medical applications

Backlog issues continue to plague the FAA Aeromedical Certification Division as it deals with more complex cases and a continued high volume of medical applications requiring Special Issuance authorization.

Recently, approval was granted to hire an additional physician reviewer based in Oklahoma City in an effort to accommodate some of the backlog, according to sources at the FAA. There are multiple ways to assist in improving the airman experience, particularly for individuals with multiple conditions.

CAMA leadership continues to work with academic center and private practice representatives to encourage the FAA to consider Specialized Interest groups that could be granted special dispensation to efficiently handle more complex cases and facilitate a rapid review process combined with creating educational opportunities for AMEs across the country to review the process. In turn, these AMEs could apply the decision-making processes to their practices to better counsel pilots on what testing is required and/or
appropriate for consideration of Special Issuance Authorization for various medical conditions.

Here are some reminders to AMEs:

- Ensure all supporting materials are submitted at one time when deferring a case and assisting an airman in collating materials to be considered for review. Piecemeal supporting data packets are one factor of many in slowing down the aeromedical certification process.
- Being aware of all conditions for which CACIs (Conditions AMEs Can Issue) are eligible and avoiding unnecessary deferrals is another way to avoid clogging the system with cases that could have been issued at the time the airman was in the office.
- When in doubt, call! Your Regional Flight Surgeon’s Office is a good resource to answer questions at a local level and may even be able to work your cases directly, given the proper circumstances. Alternatively, there is assistance available with the AMCD in Oklahoma City as well.

Although there are challenges facing all of medicine currently, a number of factors are making the aeromedical certification process even more acutely challenging now. The number of FAA-designated aviation medical examiners continues to shrink, due to an aging population of individuals trained in the specialty of Aerospace Medicine who are retiring from practice or dying. Some rural areas have very few AMEs, forcing pilots to travel long distances to obtain a flight physical. The number of specialty-trained residents and fellows continues to decline each year. Military training programs are having difficulty filling training positions each year, and primary care physicians are being told by their practice leaders in certain cases to step down from performing examinations due to poor reimbursement or perceived liability risks. The FAA continues to face manpower shortages in recruiting and retaining AMEs with experience, clinical savvy and administrative knowledge of “the system” to effectively guide pilots with increased numbers of conditions and more complex conditions.

The issue of backlog at the Aeromedical Certification Division at the FAA is not new and seems to resurface cyclically. Beyond the political clout of pilot advocacy groups that have lobbied for years to pass legislation to essentially bypass the aeromedical certification system, those organizations state that the reason we likely are where we are with alternative medical certification pathways such as BasicMed is due to slow, antiquated processes for reviewing and adjudicating medical applications. Despite valiant efforts of FAA leadership to add support for current systems by attempting to hire additional people, the FAA aeromedical organization continues to face uphill challenges with backlogs. This creates frustration of its customers – pilots and AMEs -- by falling short on its response to ongoing issues.

CAMA hopes to partner with the FAA to improve the process. However, here are a few examples of areas where complaints are often lodged in the office by pilots and heard at the organizational level by AMEs across the nation:

**Lack of communication:**

In an era when a consumer can look online and see when their carryout pizza is in the oven, why is it that it is difficult to locate a case within the aeromedical certification system and obtain a status report on it? Why are cardiology and neurology panel dates kept secret to the average AME? Pilots become frustrated and often contact their AMEs in desperation to obtain answers. It seems that there should be a way to track cases and obtain status reports without having to navigate the often insoluble call in structure in Oklahoma City – unless the AME knows someone and can occasionally obtain information by calling them directly.
Data handling gone awry:

Although AMEs can and are expected to upload ECGs electronically into DIWS, the very same system cannot handle uploads of supporting medical data that would not only save hundreds of thousands of dollars in labor the FAA expends to pay contractors to manually scan paper records into the electronic system (which is also prone to errors of omission due to losing records in the mail, or scanning data into the incorrect “tab” or file) but also could save thousands of dollars in shipping costs borne by the AMEs and/or the pilots. For years, CAMA has heard that this is due to legal reasons – but if hospitals and clinics can upload data and display electronic data directly to their patients, why is it that the FAA cannot upload data and be able to review it, given appropriate encryption and security by allowing AMEs to send PDF files?

Closed shop on Tuesdays:

How is it that the AMCD can justify turning off the phones to AMEs 20% of the time? One could argue that minimizing access for pilots might be valid, but why AMEs as well? These are the medical providers who are often calling to help solve the very problem that the concept of “surge Tuesday” is trying to solve – and that is the backlog of cases. Closing the doors to AMEs one day a week continues to frustrate AMEs who are forced to hold cases in abeyance until physician reviewers will take a call on other days of the week. This must change.

Let the private sector help:

CAMA is taking the lead in asking the FAA aeromedical leadership to consider designating Centers of Specialized Interest to be formed in order to assist with managing highly complex cases and preparing those cases in a format the will not take the decision-making power away from the FAA, but minimize the tremendous time commitment to preparing cases for panel review by FAA personnel and allowing these Specialized Centers to assist in this type of work by using a standardized template and preparing all diagnostic testing results that can be viewed remotely via video-conferencing or shared screen technology. Ultimately, facilities with trainees would have improved educational opportunities, and given the ability to present cases in a standard format, would undoubtedly save time and effort, and help speed the process of adjudicating cases.

Continue to improve the language of correspondence:

While we know that FAA lawyers guide the language of regulatory letters, correspondence from the FAA continues to be strewn with legalese and insoluble language that leave pilots frustrated, confused, and many times non-compliant, when they misunderstand the meaning or intent of various regulatory verses. Although the FAA has improved the letters over the years by allowing the AME to make a certification determination for an added year at the appropriate time frame on some letters, (e.g. expanded CACIs) the concept of a six-year AME-assisted Special Issuance Authorization continues to baffle many pilots who mistakenly believe they have been granted a six-year certificate.

Increase panel frequency when volume demands it:

Having the Neurology Panel meet once every three to four months, for example, is brutal for the pilot who unknowingly applied for his or her medical a few days after the last panel meets. Having a case on administrative hold until a panel meets is frustrating for the pilot and the AME alike.

Clearly, FAA aeromedical leadership cannot be held accountable for all perceived bottlenecks in the system. There have been and will continue to be issues in any system. However, CAMA stands willing and able to provide innovative ideas and feedback to the FAA in an effort to work together to help solve the problems of backlogged cases. After all, we are all in this together and it takes a team to make meaningful changes.
CAMA Past President, Marion C. “Buck” Wagnon, MD, Heads West

Attending the funeral service was CAMA Honorary member, Mrs. Sammie Harris. Sammie remembers Buck very well as the personal physician of CAMA Past Executive Vice President, Jim Harris.

When informed of Buck’s passing, CAMA Past President, Jack Hastings, stated, “Buck was a truly nice guy and an avid supporter of both CAMA and aviation.”

In 1991, Dr. Wagnon was awarded the CAMA-sponsord John A. Tamisiea Award by the Aerospace Medical Association.

Buck leaves behind a wife, four daughters, ten grandchildren, three great grandchildren, and a sister. He will be greatly missed, and we all wish him a safe journey as he heads West. (Information for this notice was supplied by Mrs. Sammie Harris.)

Word has been received at the CAMA Home Office that Marion C. “Buck” Wagnon, MD, passed away on June 9, 2017, in Norman, Oklahoma, at the age of 89. His funeral service was held on June 14, 2017, at the Meadowood Baptist Church in Midwest City, Oklahoma.

Buck was an active member of CAMA for many years and served as President of the organization in the past. He was born September 14, 1927, in Oklahoma City, Oklahoma. He received his MD degree from the University of Oklahoma and practiced Family Medicine for 49 years in Midwest City, Oklahoma, where he was also an FAA Aviation Medical Examiner.

Buck was a life-long avid aviator, who learned to fly before he became a physician. He loved spending time with his family and friends and as much time as possible flying his airplane. He loved anything involving aviation.

Civil Aviation Medical Association (CAMA) Contact Information:

Mailing address: CAMA
P. O. Box 2382
Peachtree City, GA 30269

Telephone: 770-487-0100
Secure FAX: 770-487-0080

Web Site: www.civilavmed.org
eMail: civilavmed@aol.com

CAMA now has a Facebook page! In order to provide the best options for communication with our members and other interested parties, we have established a Facebook page. If you are already on Facebook, you may find our page by entering “Civil Aviation Medical Association” into the search box. We will post current events, photos, and other pertinent information about our organization. You are invited to ask questions or to post comments or photos on our page (inappropriate remarks/photos or advertisements will be removed). The page is monitored several times daily, and we will strive to answer your questions promptly. Please contact the CAMA home office if you have any questions, suggestions, or comments about the Facebook page.
Are you ready for a fabulously fun and informative time at this year’s CAMA Annual Scientific Meeting?!?!

In addition to an incredible educational program from VP of Education, Robert Haddon, MD, CAMA is arranging some interesting and entertaining activities for registered attendees and their registered guests. Our host hotel is the Sheraton Greensboro at Four Seasons in Greensboro, North Carolina. The link for making your hotel reservations is:

https://reservations.travelclick.com/2576?groupId=1779530#guestsandrooms

The hotel reservation web site is not quite as intuitive as we would like, but if you click on the day that you wish to arrive and then on the day you wish to depart, your reservation should show the correct days of your hotel stay. The entire week is shown as possible for reservations, as we have some participants who wish to arrive a few days in advance or to depart a few days later. Let the CAMA home office know if you have difficulties making a reservation, and we will be glad to assist you. Rooms are $136.00 per night, plus applicable taxes. The hotel telephone number is 336-292-9161. The block is under “Civil Aviation Medical Association.”

CAMA will provide registered attendees and registered guests a breakfast buffet and a luncheon buffet on each of the meeting days (Thursday, Friday, and Saturday), plus a field trip with a catered dinner on Thursday evening and the Honors Night Banquet on Friday evening. There will be a featured Keynote Speaker at the banquet for your entertainment, along with presentations and awards, and the announcement of the 2018 CAMA Officers and Trustees.

North Carolina is part of the birthplace and rich heritage of American stock car racing, so for our Thursday field trip, we will first go to a hangar party at the Signature Flight Services / FBO at Piedmont Triad Airport, where Honda Jet will have one of their newest beautiful aircraft for us to look over. Thanks to Honda Jet Regional Sales Manager, Glenn Gonzales, for providing this incredible aircraft for our pleasure! There will also be several exotic cars from local dealerships for us to see and wish over (Taking home a new Lamborghini or Ferrari or BMW would be quite fun, wouldn’t it?! - They will be for sale!).

Once we have sufficiently enjoyed the aircraft and cars, we will visit the Richard Childress Racing Museum in Welcome, NC, for a southern inspired dinner!!! It is about a 35-40 minute bus ride from our hotel, and is filled with beautiful cars driven by such NASCAR greats as Dale Earnhardt, Sr., Kevin Harvick, Ryan Newman, Austin Dillon, Paul Menard, and others. Dale Earnhardt’s #3 car is set up so that individuals may sit in the driver’s seat and take photos—a special door has been added to the car, so that we don’t have to climb in the window, thankfully!

The Annual Scientific Program/Agenda is complete and has been submitted to the American Academy of Family Physicians (AAFP) for a CME rating. Once that action is complete, the program will be submitted to the American Board of Preventive Medicine (ABPM) for evaluation for a Maintenance of Credit (MOC) rating. Both types of credits will be reflected on the course certificates that each participant will receive at the completion of the meeting on Saturday afternoon. If your spouse or registered guest is also a medical professional in need of a CME/MOC certificate, please let us know as soon as possible, so that the certificates can be prepared in advance. A copy of the meeting program/agenda is on Pages 8-10 of this publication. Of course, the program will be emailed in advance to all those registered for the
annual meeting, and copies will be passed out to all participants in Greensboro.

The theme for the event is “Pilot Performance in the Era of BasicMed” and will feature information from a multi-disciplinary perspective in promoting pilot health, aviation safety, and AME performance for correctly evaluating, diagnosing, and processing medical applications for pilots with complex medical conditions and those without a history of chronic diseases. The meeting will be applicable, as always, to all aviation-related personnel, including those who assess and work with professional pilots. This meeting will be sanctioned for FAA Aviation Medical Examiner refresher training, and also provide both CME and MOC credits for participants.

If you plan to fly your own aircraft into Greensboro, NC, for the meeting, the FBO is Signature Flight Support, Piedmont Triad International Airport, 1060 PTI Drive, Greensboro, NC, 27409. Their web site is: www.signatureflight.com/locations/gso. Using this web site, you can make a reservation for your aircraft and schedule any services you require. The telephone number is 336-668-0481, and the email address is GSO@signatureflight.com. A complete listing of services and products is available on their web site.

The meeting registration form is on Page 7 of this publication. A copy is also available on the HOME page of the CAMA web site at www.civilavmed.org. Complete the form and submit to the CAMA Home Office by email to civilavmed@aol.com, by fax to 770-487-0080, or in hardcopy to CAMA, P. O. Box 2382, Peachtree City, GA 30269. CAMA members receive discounted pricing for registration, so if you are not yet a member of CAMA and wish to pay the member price for the annual meeting, please complete the 2017 membership form on Page 28 or from the web site, and submit it with your registration form.

The hotel catering staff and field trip caterers can accommodate any dietary restrictions, gluten intolerance, vegan preferences, food allergies, etc., as necessary. If you have any food considerations that the catering staff needs to know about, please include that information in the appropriate blank on the registration form, so that special plates can be prepared for you.

We ask that a cell phone number be included in your registration, for emergency use only. We have had emergency situations in the past where we needed to reach someone attending the meeting and were unable to do so in a timely manner because we didn’t have a cell phone number. Your cell number will not be used except in an emergency and will not be given out to anyone else. The emergency contact during the meeting is Sherry Sandoval, CAMA Operations Manager. Her cell phone number is 214-676-2442. The CAMA email will also be monitored closely during the meeting as a second method of contact.

As a wonderful bonus this year, Shelli Stanton of the Visit Anchorage! convention and visitors bureau will be exhibiting at the meeting with information, brochures, coupons, and other exciting materials from Anchorage and Alaska to highlight local attractions that will be available for meeting participants and their guests and families during our Annual Scientific Meeting in Anchorage September 27-29, 2018, at the Captain Cook Hotel. Be sure to stop by and visit with Shelli and take advantage of the materials she will be exhibiting and handing out.
CIVIL AVIATION MEDICAL ASSOCIATION  
ANNUAL SCIENTIFIC MEETING, SEPTEMBER 14-16, 2017  
SHERATON GREENSBORO AT FOUR SEASONS, GREENSBORO, NORTH CAROLINA

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<thead>
<tr>
<th>ATTENDEE NAME &amp; TITLE</th>
<th>AME NUMBER</th>
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*(MD, DO, MBCH, PhD, MS, etc.)* SPECIALTY:

ARE YOU BRINGING A SPOUSE OR OTHER GUEST(S) WHO WILL PARTICIPATE IN THE MEETING, WILL BE EATING MEALS WITH YOU, GOING ON THE FIELD TRIP WITH YOU?

| YES | ? | NO | ? |

SPOUSE/GUEST NAME:

NOTE: There is a $375.00 registration fee for each participating guest to cover eight meals and the field trip. (Tickets to the field trip and/or banquet will NOT be sold separately.)

ATTENDEE ADDRESS:

(Please use the address you wish to be used in the participant roster that will be given to all in attendance)

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<tr>
<th>CITY</th>
<th>STATE/PROVINCE</th>
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ZIP:

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<th>COUNTRY</th>
<th>PHONE</th>
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EMAIL (REQUIRED):

CELL PHONE:

DO YOUR OR YOUR GUEST HAVE ANY SPECIAL DIETARY NEEDS?

| YES | ? | NO | ? |

PLEASE DESCRIBE: (VEGAN, VEGETARIAN, GLUTEN INTOLERANT, ETC.)

REGISTRATION FEE MAY BE PAID BY CHECK (U.S. DOLLARS) OR CREDIT CARD


CREDIT CARD NUMBER: SECURITY CODE (CVV): ZIP CODE OF CARD BILLING ADDRESS

EXPIRATION DATE: SIGNATURE:

AUTHORIZED CHARGE AMOUNT (U.S. DOLLARS):

CHECK ENCLOSED (U.S. DOLLARS): CHECK AMOUNT:

PERSONS REGISTERING TO ATTEND THE CAMA ANNUAL SCIENTIFIC MEETING - PLEASE MAKE YOUR HOTEL RESERVATIONS ONLINE BY USING THE FOLLOWING LINK: https://reservations.travelclick.com/2576?groupID=1779530/#guestsandrooms

This is a special link exclusively for CAMA Meeting attendees to use to receive the special CAMA room rate of $136.00, plus applicable fees and taxes, for 1 to 4 persons. All reservations must be made by August 14, 2017, to receive the Cama rate and for availability.

| CAMA MEMBER REGISTERED ON OR BEFORE AUGUST 14, 2017 | $685.00 U.S. DOLLARS |
|CAMA MEMBER REGISTERED AFTER AUGUST 14, 2017 | $735.00 U.S. DOLLARS |
|SPOUSE/GUEST OF ATTENDEE | $375.00 U.S. DOLLARS |
|*NON-MEMBER REGISTERED ON OR BEFORE AUGUST 14, 2017 | $835.00 U.S. DOLLARS |
|*NON-MEMBER REGISTERED AFTER AUGUST 14, 2017 | $885.00 U.S. DOLLARS |

NOTE: Registration and guest fees include 8 meals – Buffet breakfast and lunch on Thursday, Friday, and Saturday, a field trip with a catered dinner on Thursday night, and the Honors Night Banquet at the Sheraton Greensboro on Friday Night. No activities are scheduled for Saturday evening.

*NON-MEMBERS - IF YOU WISH TO REGISTER AT THE LOWER MEMBER RATE, YOU MAY BECOME A MEMBER OF CAMA BY REQUESTING A 2017 MEMBERSHIP FORM. YOU MAY COMPLETE AND RETURN IT AND YOUR 2017 DUES PAYMENT WITH YOUR REGISTRATION FORM.

RETURN REGISTRATION FORMS BY EMAIL, FAX, OR REGULAR MAIL TO:

CIVIL AVIATION MEDICAL ASSOCIATION  
P. O. BOX 2382, PEACHTREE CITY, GA 30269  
PHONE: 770-487-0100  
FAX: 770-487-0080  
EMAIL: civilavmed@aol.com

Registration forms may be returned by FAX or eMail (civilavmed@aol.com) if you are using a credit card for payment or registration fee(s). All registrations received will be acknowledged by email, so an email address is required. If you do not receive a confirmation email that your registration has been received, please contact CAMA. We do not share email addresses with any other groups or individuals – the email address is strictly for our use in communicating with you with regard to CAMA activities.

THIS MEETING IS APPROVED FOR FAA-AME PERIODIC TRAINING. CME & MOC HAVE BEEN APPLIED FOR.
"Pilot Performance in the Era of BasicMed"

**AGENDA**

**WEDNESDAY, SEPTEMBER 13, 2017**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>04:00 PM to 06:00 PM</td>
<td>CAMA Board Meeting</td>
<td>Biltmore Room, Sheraton</td>
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<tr>
<td>07:00 PM to 09:00 PM</td>
<td>Meeting Registration</td>
<td>Registration Desk 2</td>
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**THURSDAY, SEPTEMBER 14, 2017**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>07:00 AM to 08:00 AM</td>
<td>Breakfast Buffet</td>
<td>Guilford F, Sheraton</td>
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<tr>
<td>08:00 AM to 08:30 AM</td>
<td>Welcome and Introductions</td>
<td>Guilford G, Sheraton</td>
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</tbody>
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**Welcome from CAMA**

- Clayton T. Cowl, MD, MS
  - President, CAMA
- Robert Haddon, MD, MS
  - Vice President of Education, CAMA
- David P. Millett, MD, MPH
  - Executive Vice President, CAMA

**Welcome from FAA/CAMI**

- Deann King, Ed.D, Team Lead, FAA FAA Aerospace Medical Education Division, Oklahoma City, OK

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>08:30 AM to 09:30 AM</td>
<td>AME Program Overview and Performance</td>
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<td></td>
<td>Stephen Veronneau, MD, MS</td>
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<td></td>
<td>Manager, FAA Aerospace Medical Education Division, Oklahoma City, OK</td>
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<tr>
<td>09:30 AM to 09:45 AM</td>
<td>Morning Break</td>
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<td>09:45 AM to 10:45 AM</td>
<td>Aeromedical Assessment Updates from the Federal Air Surgeon’s Office</td>
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<td>Stephen H. Goodman, MD</td>
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<td>Deputy Federal Air Surgeon, Washington, D. C.</td>
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<tr>
<td>10:45 AM to 11:45 pm</td>
<td>Certification Issues - Diabetes, Thyroid CACI, Medication, Vertigo/ENT</td>
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<td></td>
<td>Warren S. Silberman, DO, MPH</td>
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<td>Medical Officer, FAA Aerospace Medical Education Division, Oklahoma City, OK</td>
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<td>11:45 PM to 12:45 PM</td>
<td>Luncheon Buffet</td>
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<tr>
<td>12:45 PM to 01:45 PM</td>
<td>“Cardiology FAA Update”</td>
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<td>John S. Raniolo, DO</td>
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<td>Cardiologist and FAA Cardiology Consultant</td>
<td>Phoenix, AZ</td>
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<tr>
<td>01:45 PM to 02:45PM</td>
<td>Medical Legal Issues</td>
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<td>Amanda Sheridan FAA Senior Attorney, Enforcement Division, Office of Chief Counsel, FAA, Washington, DC</td>
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<tr>
<td>02:45 pm TO 03:00 PM</td>
<td>Afternoon Break</td>
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<tr>
<td>03:00 PM to 04:00 PM</td>
<td>“The Aging Pilot”</td>
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<td></td>
<td>Robert Haddon, MD, MS</td>
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<td></td>
<td>Aerospace Medicine Specialist, Preventive Medicine, Mayo Clinic, Rochester, MN</td>
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04:00 PM  Adjourn
04:45 PM  Load Buses for Field Trip
           Entrance F - Casual Dress
05:00 PM – 10:00 PM  Field Trip and Catered Dinner
           Signature Flight Services & Richard Childress Racing Museum

FRIDAY, SEPTEMBER 15, 2017

07:00 AM to 08:00 AM  Breakfast Buffet
           Guilford F, Sheraton
08:00 AM to 09:00 AM  “Aviation Neurology”
           John D. Hastings, M. D.
           FAA Consultant and Neurologist, Tulsa, OK
09:00 AM to 10:00 AM  “Space Environment & Physiology”
           Robert Haddon, MD, MS
           Aerospace Medicine Specialist, Preventive Medicine, Mayo Clinic, Rochester, MN
10:00 AM to 10:15 AM  Morning Break
10.15 AM to 11:15 AM  “Addiction, PTSD, & Preventing Pilot Catastrophic Events”
           Daniel Danczyk, MD, MPH
           Psychiatrist, Mayo Clinic, Rochester, MN
11:15 AM to 12:15 AM  ENT FAA Update
           David Schall, M. D., MPH
           Regional Flight Surgeon, FAA Great Lakes Region
           Des Plaines, IL
12:15 AM to 01:15PM  Luncheon Buffet
           Guilford F, Sheraton
01:15 AM to 02:30 PM  “Obstructive Sleep Apnea and Fatigue”
           David Schall, MD, MPH
           Regional Flight Surgeon, FAA Great Lakes Region
02:30 PM to 03:30 PM  “Ophthalmology FAA Updates & Prevention of Eye Disease”
           Alan M. Kozarsky, MD
           Ophthalmologist, Eye Consultants of Atlanta, GA
03:30 PM to 3:45 PM  Afternoon Break
03:45 PM to 05:00 PM  “Mental Fitness to Fly: Psychiatry Updates & the HIMS Program”
           Daniel Danczyk, MD, MPH
           Psychiatrist, Mayo Clinic, Rochester, MN
05:00 PM  Adjourn
6:00 PM to 7:30 PM  CAMA Honors Night Banquet
           Guilford F, Sheraton
7:30 PM to 9:30 PM  Keynote Presentation:
           “Space Medicine Certification”
           Richard S. Williams, MD, Senior Advisor for Health & Medical Policy,
           Office of the Chief Health & Medical Officer, NASA

SATURDAY, SEPTEMBER 16, 2017

07:00 AM to 08:00 AM  Breakfast Buffet
           Guilford F, Sheraton
08:00 AM to 09:15 AM  “Complex Aeromedical Assessment”
           Robert Haddon, MD, MS
           Aerospace Medicine Specialist, Preventive Medicine, Mayo Clinic, Rochester, MN
09:15 AM to 10:30 AM  “Infectious Disease Update—Catch Up on What Not to Catch”
           Richard S. Roth, MD, Director of Infectious Disease Training, Memorial Health University Medical Center,
           Savannah, GA
10:30 AM to 10:45 AM  Morning Break
10:45 AM to 12:00 AM  “Pulmonary Diseases and Pilot Performance”
           Clayton T. Cowl, MD, MS
           Pulmonologist, Occupational Medicine Specialist, Chair, Preventive, Occupational and Aerospace Medicine,
           Mayo Clinic, Rochester, MN
12:00 PM to 01:00 PM  Luncheon Buffet  
Guilford F, Sheraton

01:00 PM to 02:00 PM  Panel Discussion: “Issues in Medical Regulation”  
Moderator: Stephen Veronneau, M.D., MS  
Manager, FAA Education Division

Panel Members:
Stephen H. Goodman, MD, Deputy Federal Air Surgeon  
John S. Raniolo, DO, Cardiology  
John D. Hastings, MD, Neurologist  
Daniel Danczyk, MD, MPH, Psychiatrist/Addiction  
David Schall MD, Regional Flight Surgeon ENT

02:00 PM to 02:15 PM  Afternoon Break

02:15 PM to 04:45 PM  Case Study & Panel Discussion: “Would You Fly With This Pilot? - Aeromedical Decision-Making”

**Adjourn

**Please pick up your CME Certificate from the CAMA table and turn in your FAA testing material to the FAA representative prior to your departure.

No CAMA activities are planned for Saturday evening. You are free to plan your own activities for the evening or to depart for home if you prefer.

Emergency Contact During the Meeting:  
Sherry Sandoval, CAMA Operations Manager  
Cell phone 214-676-2442

PROGRAM OBJECTIVES:
To understand and apply the changes in aviation medicine to the individual’s private practice  
To assess specific clinical conditions/disciplines with respect to aviation medicine to correctly utilize the Federal Aviation medical standards with the specific conditions discussed  
To Comprehend the FAA medical program initiatives  
To understand to be able to work with the aeromedical certification system  
To comprehend the legal aspects of being an AME  

This program is approved for FAA-AME training.

CONTINUING MEDICAL EDUCATION

This Live activity, Civil Aviation Medical Association Annual Scientific Meeting, with a beginning date of 09/14/2017, has been submitted to the American Academy of Family Physicians (AAFP) and to the American Board of Preventive Medicine (ABPM) for CME and MOC ratings.

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This is the last edition of our publication, "The Flight Physician" prior to the CAMA Annual Scientific Meeting in Greensboro, NC, September 14-16, 2017. There is a lot of interesting information about what to expect at this year’s meeting, along with the program/agenda and a registration form in this August edition. Please take time to read about the meeting on Pages 5 and 6, and to send a completed registration form to CAMA as soon as possible, so that we can reserve a spot at the meeting for you.

I would like to share with you the following press release from the Governor General’s Office regarding Sir Rodney Williams, long time AME, CAMA member, CAMA Board of Directors Trustee, and Governor General of Antigua and Barbuda:

"HIS EXCELLENCY SIR RODNEY WILLIAMS PRESENTED WITH MAVIS CABRAL MEDICAL CENTRE GOLD MEDAL HONOUR AWARD FOR DISTINCTION IN HEALTH CARE"

At a ceremony held on Saturday July 8, 2017, His Excellency Sir Rodney Williams KGN, GCMG, KSt.J, MBBS was presented with the Mavis Cabral Medical Centre Gold Medal Honour Award for distinction in Health Care.

Prior to the presentation, His Excellency’s contribution to medical services and the health of the nation was described as outstanding and his efforts lauded as being above and beyond the call of duty. The range of medical expertise demonstrated by the well known and respected practitioner includes family, aviation and sports medicine. He has been practicing for over forty years, and often provides free care for the needy in keeping with his personal belief that a person’s health should not be determined by a person’s wealth.

The gold medal and certificate were presented by the Chairperson of the Mavis Cabral Medical Centre Second Chance Foundation Inc., Mr. Kevin Gomez. The Foundation is the charitable arm of the Mavis Cabral Medical Centre and helps to offset the cost of medical care for the needy. The Centre is based in one of the largest rural communities in Antigua and Barbuda with the objective of providing medical access to those who reside outside of the city and away from the main medical facilities.

His Excellency Sir Rodney Williams expressed his appreciation to all gathered, especially the MCMC Chief of Medical Staff, Dr. James Sutton, who along with his widow had founded the health care facility."

CAMA congratulates Sir Rodney on this very prestigious award!
Mosquitoes cause more human suffering than any other organism -- over one million people worldwide die from mosquito-borne diseases every year. Not only can mosquitoes carry diseases that afflict humans, they also transmit several diseases and parasites that dogs and horses are very susceptible to. These include dog heartworm, West Nile virus (WNV) and Eastern equine encephalitis (EEE). In addition, mosquito bites can cause severe skin irritation through an allergic reaction to the mosquito's saliva - this is what causes the red bump and itching. Mosquito vectored diseases include protozoan diseases, i.e., malaria, filarial diseases such as dog heartworm, and viruses such as dengue, encephalitis and yellow fever. The CDC Travelers’ Health provides information on travel to destinations where human-borne diseases might be a problem.

Encephalitis

Mosquitoes can pass on viruses that cause inflammation around your brain and spinal cord. (The endpoint with a serious West Nile infection is encephalitis.) What type you could get depends on where you are:

- LaCrosse -- the 13 states east of the Mississippi River
- St. Louis -- throughout the U.S., especially Florida and Gulf of Mexico states
- Eastern Equine -- Atlantic, Gulf Coast, and Great Lakes states; the Caribbean; Central and South America
- Western Equine -- states west of the Mississippi River, areas of Canada and Mexico
- Japanese -- Asia and the Western Pacific

The CDC recommends the use of products containing active ingredients which have been registered with the U.S. Environmental Protection Agency (EPA) for use as repellents applied to skin and clothing. Of the products registered with the EPA, those containing DEET, picaridin, IR3535, and some oil of lemon eucalyptus and para-menthane-diol products provide longer-lasting protection.

EPA registration means that EPA does not expect the product to cause adverse effects to human health or the environment when used according to the label.

Always follow the recommendations appearing on the product label. EPA recommends the following when using insect repellents:

- Apply repellents only to exposed skin and/or clothing (as directed on the product label). Do not apply repellents under your clothing.
- Never use repellents over cuts, wounds or irritated skin.
- Do not apply to eyes or mouth, and apply sparingly around ears. When using repellent sprays, do not spray directly on your face—spray on your hands first and then apply to your face.
- Do not allow children to handle or spray the product. When using on children, apply to your own hands first and then put it on the child. Avoid applying repellent to children’s hands because children frequently put their hands in their eyes and mouths.
- Use just enough repellent to cover exposed skin and/or clothing. Heavy application does not give you better or longer lasting protection.
- After returning indoors, wash treated skin with soap and water or bathe. This is particularly important when repellents are used repeatedly in a day or on consecutive days.
- If you (or your child) get a rash or other reaction from a repellent, stop using the repellent, wash the repellent off with mild soap and water, and call a local poison control center for further guidance. If you go to a doctor, it might be helpful to take the repellent with you.

Using the right insect repellent and other preventive actions can discourage mosquitoes, ticks and other biting insects from landing on you.

Symptoms to Look for:

The three most common symptoms of mosquito-borne illnesses are:
1. Fever
2. Fatigue
3. Headache

This would apply whether you have recently traveled

Richard S. Roth, MD Infectious Disease Specialist, Savannah, GA and prior Program Director of the ID Training Program, Memorial Health University Med. Center, Mercer Univ. School of Medicine. Dr. Roth is a Senior AME, holds a multi-engine ATP and is Type Rated in the Lear 60 and Gulfstream G550 series aircraft. Dr. Roth also ground and simulator instructs the G550 initial program at the Flight Safety Savannah, GA training center. He serves as a Trustee on the CAMA Board of Directors and a consultant to the Federal Air Surgeon.

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somewhere where outbreaks of mosquito-borne illnesses are common or you’ve recently been bitten at home.

Diseases You Can Catch From Mosquitoes:

What are some of the most common mosquito-borne illnesses? Watch out for the following symptoms, especially if you have traveled anywhere where there are outbreaks:

**West Nile Virus** — West Nile Virus is spread by mosquitoes and can lead to meningitis, a potentially fatal inflammation of the brain. Symptoms can include fever, fatigue, headache, back and body aches, stiff neck, vomiting or nausea.

**Chikungunya** — Chikungunya is another mosquito borne virus that’s very common in Asia and has recently spread to the Caribbean. This virus can cause fever, fatigue, headache, joint pain and swelling, or a rash. The worst symptom of Chikungunya is extreme joint pain, which can last for days, weeks and sometimes even months.

**Malaria** — Malaria is a potentially fatal disease that is caused by a parasite. This parasite infects mosquitoes, and infected mosquitoes spread the disease to humans. Malaria kills millions of people around the world every year. Symptoms can be flu-like and can include fever, fatigue, headache, low body temperature and sweating, anxiety and chills.

**Yellow Fever** — Yellow fever is a virus that can affect the liver. It is transmitted by mosquitoes, especially in Africa and South America. Symptoms include fever, fatigue, headache, chills, light sensitivity, vomiting and nausea, redness of the tongue, face and eyes, and aches and pains.

**Dengue Fever** — Dengue is a virus, and it’s considered one of the deadlier mosquito-borne illnesses, especially in tropical climates. Patients can experience symptoms such as fever, fatigue, headache, bleeding gums, pain behind the eyes, pain in the muscles, bones and joints.

**Arboviral Encephalitis** — Ticks, mosquitoes and other pests can transmit the arbovirus, which can lead to life-threatening inflammation of the brain. At first, symptoms might be flu-like and can include fever, fatigue and lethargy, headache, stiff neck and confusion.

If a mosquito bites you or you travel somewhere where mosquitoes are common — and if you develop a fever, headache and fatigue and your symptoms are combined with any other symptoms listed above, seek medical help immediately.
How to Prevent Mosquito Bites

Keeping your family – and yourself – healthy and happy by protecting yourself from mosquito bites. Using mosquito traps can reduce the population of mosquitoes around your home and therefore lessen your chances of getting bitten. Mosquito traps lure and then suck mosquitoes into a sealed chamber where they dehydrate and die within 24 hours.

Remove Mosquito Habitats

- Eliminate standing water in rain gutters, old tires, buckets, plastic covers, toys, or any other container where mosquitoes can breed.
- Empty and change the water in bird baths, fountains, wading pools, rain barrels, and potted plant trays at least once a week to destroy potential mosquito habitats.
- Drain or fill temporary pools of water with dirt. Keep swimming pool water treated and circulating.

Use Structural Barriers

- Cover all gaps in walls, doors, and windows to prevent mosquitoes from entering.
- Make sure window and door screens are in good working order.
- Completely cover baby carriers and beds with netting.

Avoid Getting Bitten

- Keep mosquitoes away from exposed skin by wearing long-sleeved shirts, long pants, and socks.
- Tuck shirts into pants and pants into socks to cover gaps in your clothing where mosquitoes can get to your skin.
- Stay indoors when possible, especially if there is a mosquito-borne disease warning in effect.
- Use repellents when necessary and follow label directions and precautions closely.
- Use head nets, long sleeves and long pants if you venture into areas with high mosquito populations, such as salt marshes.
- Replace your outdoor lights with yellow “bug” lights, which tend to attract fewer mosquitoes than ordinary lights. The yellow lights are NOT repellents, however.
Table 1. Advantages and disadvantages of each surveillance tool from a mosquito control operation perspective.

<table>
<thead>
<tr>
<th></th>
<th>Denominator data</th>
<th>Sampling effort required</th>
<th>Turnaround time for results</th>
<th>What do results mean?</th>
<th>Can historical comparisons be made?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentinel Chickens</td>
<td>YES</td>
<td>Limited in an established program</td>
<td>1-2 weeks</td>
<td>Recent, Local transmission</td>
<td>YES</td>
</tr>
<tr>
<td>Horses</td>
<td>YES</td>
<td>Passive</td>
<td>4-6 weeks</td>
<td>Recent, local transmission if horse has not been recently relocated</td>
<td>YES</td>
</tr>
<tr>
<td>Mosquitoes</td>
<td>YES</td>
<td>Extensive</td>
<td>6 weeks or longer (low priority)</td>
<td>Nothing in terms of transmission or implicating are vector; virus likely present in area</td>
<td>YES</td>
</tr>
<tr>
<td>Wild Birds</td>
<td>YES</td>
<td>Extensive (permits required)</td>
<td>Sear=1 week; blood=weeks</td>
<td>Depends on recapture rate; positive juveniles indicate recent transmission</td>
<td>NO</td>
</tr>
<tr>
<td>Dead Birds</td>
<td>NO</td>
<td>Passive (not reliable)</td>
<td>Weeks or longer</td>
<td>A bird infected with the virus sometime in the past died at a particular location</td>
<td>NO</td>
</tr>
<tr>
<td>Humans</td>
<td>YES</td>
<td>Passive</td>
<td>4-6 weeks</td>
<td>Too late for timely decisions about mosquito control operations; Infected mosquitoes are likely, but may not still be around</td>
<td>YES</td>
</tr>
</tbody>
</table>

Footnotes

1. This document is Fact Sheet ENY-699 one of a series of the Entomology and Nematology Department, Florida Cooperative Extension Service, Institute of Food and Agricultural Sciences, University of Florida. Date first published: March 2004. Please visit the EDIS Web site at http://edis.ufl.edu

2. C. Roxanne Rutledge, assistant professor, Entomology and Nematology Department, Florida Medical Entomology Laboratory, Cooperative Extension Service, Institute of Food and Agricultural Sciences, University of Florida, Vero Beach, FL 32962.
There are a couple of items to report to our membership this month. While working cases in my current capacity, I have noticed an increase in our International AME’s providing documents that are not translated into English. This obviously will result in delays for their airmen. Ideally, the airman should have the reports they are provide translated by a professional. I have permitted the AME to translate the pertinent portions of the report. It is NOT acceptable for the airmen themselves to translate a document. I think that would be obvious.

Another issue, involves First-class electrocardiogram interpretation. Overall, I have been pleased that most AMEs will make a note in Block 60 concerning an abnormal EKG and do send the airman for an evaluation. Please recall that I have gone on record instructing AMEs, if you send an airman out for an evaluation, and they come back with a negative report, you may issue the medical certificate. Please mail AMCD all of the testing results. This would include all of the computer print-outs, the 12-lead electrocardiograms from a stress test, and all computer print outs and representative tracings from a Holter monitor study. Please do not note an abnormality and just inform the airman that they may hear back from the FAA! That would be grounds for an “error” on your record.

Since the medical certification division at the FAA want you to be able to find answers to your certification questions online, following is a case example. See what you think would be the way to manage it.

To refresh your memory, you would go to the FAA website at (http://www.faa.gov/other_visit/aviation_industry/designees_delegations/designee_types/ame/). From there you click “Online Resources,” where you are taken to the Guide for Aviation Medical Examiners. From the next screen, you can use your intuition to determine where to search. The Applicant History link will take you to the medical history questions on the front side of the FAA exam form. The Aerospace Medical Dispositions link takes you to the physical examination section.

NOTE: Please submit any AME-related questions you wish answered to civilavmed@aol.com for Dr. Silberman. Please indicate in your emailed question your city and state or city and country, and state whether or not you wish to have your real name used in the column. Dr. Silberman will answer your question in his column and may also contact you directly via email to provide a timely personal answer.

CASE EXAMPLE:

A 55 y/o First-class airman developed rectal bleeding. Colonoscopy was performed and demonstrated a sessile lesion in the upper descending colon. A CEA study was performed, and it was 6 ng/ml. A resection of the tumor is performed. A colostomy was not done. Pathology revealed an adenocarcinoma that went into the muscularis, but not through the bowel wall. There were no lymph nodes involved. The airman did undergo neoadjuvant chemotherapy.

The airman knows that the FAA will not allow airmen undergoing chemotherapy to be granted certification, so he waits till one-month post completion and goes in for a new FAA exam. He hand-carries the above information. He provides a current status report from the treating oncologist and a current CEA that was normal range.

You perform his exam, and he meets all first-class standards with the exception of the new condition. What do you do now?

Click on the link for Aerospace Medical dispositions. Then go to the link #38—“Abdomen and Viscera”—and click there. Once again, click Aerospace Medical Dispositions. This takes you to another page where you click on a link to “Malignancies.” This finally takes you to the Disposition Chart, and under “C.”—“Non metastatic and no High Risk features (Less than 5 years),” where you see a star that describes what the High Risk features are. As you read down the column, note that you cannot CACI an airman, if there was a CEA increase and Chemotherapy ever (including neoadjuvant). At that point you would follow “D.” and provide all that is listed under Evaluation Data. You see under the third column over that you will have to defer the case for consideration of special issuance.

This is how the FAA instructs you to work a potential medical condition case.
Clearing patients for takeoff a new duty for internists
By Mollie Durkin


If Mr. Jones believes he’s healthy enough to fly a plane, he might just ask his internist to clear him to clear him for takeoff.

As of May 1, private not-for-hire pilots no longer need to go to aviation medical examiners to be medically qualified to fly. Instead, provisions in the Federal Aviation Administration (FAA) Extension, Safety, and Security Act of 2016 allow them to use an alternative pathway, FAA BasicMed, to acquire medical qualification without obtaining a Class III medical certificate. Congress passed the legislation that was signed into law by President Obama on July 15, 2016.

In effect, eligible pilots (aviators flying five or fewer passengers in an aircraft weighing up to 6,000 pounds at altitudes of up to 18,000 feet, even in weather requiring dependency on instruments alone) can now request a comprehensive physical examination and medication review from any state-licensed physician.

Each year, more than 100,000 pilots will be eligible for the alternative pathway to medical qualification, said pulmonologist and aerospace medicine specialist Clayton T. Cowl, MD, MS, president of the Civil Aviation Medical Association, which represents FAA-designated aviation medical examiners. “It’s not exactly down the middle of the fairway for the ACP constituency, but they’re going to be directly affected by this,” he said.

Dr. Cowl, a commercial pilot, chairs the division of preventive, occupational, and aerospace medicine and holds a joint appointment in the division of pulmonary and critical care medicine at Mayo Clinic in Rochester, Minn. He recently spoke with ACP Internist about what internists need to know if they’re asked to sign off on a pilot’s health.

Q: What kind of exam will internists be expected to perform?

A: For an average internist seeing a pilot, most of them aren’t doing, for example, visual acuity or color vision, which are testing requirements outlined on the form. It is required that the internist do the full exam, review all medications, and then sign off and say, “I attest that I’ve done the full exam, I’ve talked to them about all potential medication effects, including any untoward side effects of drugs (meaning prescribed or not),” and then physicians are required to enter their name, office address, their medical license number, and the state where they practice on it. As an organization of aviation medical examiners who have undergone training at the FAA and complete required recurrent training every three years, we’re trying to make sure that internists are aware that this evaluation isn’t a summer camp physical. For some of those practices that don’t see pilots regularly and don’t really know FAA medical regulations, it could be perceived as a liability issue. At a minimum, the exam really shouldn’t be something that’s signed off as an afterthought. These exams will likely be audited and, frankly, when it really matters, of course, is if some untoward event happens, and then the exams could be scrutinized.

Q: What kind of paperwork is involved? Does the patient provide it?

A: The pilot is told in the instructions to print off and bring the form (FAA Form 8700-2) with them to the visit as a hard copy. It will be available on the FAA website, so a physician could print it off. A physician is not obligated to do the exam; it’s at their discretion. And if they do elect to do the exam, they use their clinical judgment as to what additional testing might be required to establish clinical stability. They’re signing an attestation statement on the form that says, “I think this pilot is safe to fly.” So if someone comes in with four-vessel coronary artery disease and had a heart attack six months ago, the internist may elect to do some sort of functional study after reviewing the records from their cardiologist. For example, the internist may suggest an exercise stress test or laboratory evaluation, or maybe even have them bring back a report from their cardiologist saying, “I think that the pilot is clinically stable.” To sign off on something without having any data at all is probably not the best decision in the world in terms of liability.

(Continued on Page 20)
Q: How long should physicians expect the exam to take?

A: I think for any doctor who performs a comprehensive examination, such as a full annual physical, they know what that encompasses. It should probably fit into that paradigm, plus there should be a review of records for pilots with multiple conditions with the potential to affect piloting performance. In other words, this isn’t a brief, 10-minute follow-up visit to discuss someone’s blood pressure medication; this is a full, comprehensive exam, and it probably should be scheduled as such. Since the signoff on the exam is at the discretion of the physician, having a clear paper trail showing that all chronic medical conditions, such as diabetes, coronary disease, cancer, psychiatric conditions, substance abuse, or other conditions, are followed closely and are clinically stable is necessary.

Q: What are the most important things that internists should know about FAA regulations as they pertain to BasicMed?

A: There’s an entire FAA examiner’s guidebook available online on the FAA.gov website. There’s roughly 3,000 aviation examiners nationally who are available to answer questions and serve as a resource, but I think using common sense and having a little bit of diagnostic curiosity and taking a very good medical history, making sure that if there are things that are unanswered (for example, a stroke without any follow-up or substance abuse without treatment or aftercare), there probably needs to be some additional materials obtained before that individual should be signed off.

Q: If a doctor does not clear a patient, does the pilot have any recourse? Can they go to a different doctor?

A: Sure. They can go to as many different providers as they want until they get someone to sign off on it. The only stipulation in the legislation is that the individual who signs off must be a state-licensed physician. In essence, the signoff must come from someone who’s willing to put their medical license number down on it and attest that they’ve done the full exam and it is their opinion that, based upon the data they have reviewed, the individual pilot is safe to fly.

Q: How often are pilots required to renew their medical qualifications?

A: Not every pilot gets a new exam every year, with the exception of professional pilots. For a healthy pilot over age 40, the usual FAA Class III exam is good for two years, and if you’re under age 40, it’s good for five years. Using FAA BasicMed, pilots over 40, even if they have serious health problems, it’s four years until that pilot actually has to undergo another exam. Every two years, the pilot exercising the BasicMed alternative to medical certification must take an online course and attest to the fact that he or she is under the care of a state-licensed physician for their medical conditions. For specific neurological issues like stroke, loss of consciousness without a specific known reason, or seizure disorder, then pilots pursuing BasicMed must certify every two years that they are under the care of a state-licensed specialist. Same thing for psychiatric-related diseases. And then every four years, the specialist or an internist needs to examine the pilots, complete a comprehensive medical examination checklist, and state that the pilot remains safe to fly.

Q: What is the likelihood that internists will encounter this exam request? Are some more likely than others to see these pilots?

A: Looking at the FAA data, last year there were approximately 98,000 Class III medical exams completed. There are some geographic regions with populations of more pilots, typically in areas where the weather is more conducive: the Southeast, particularly in Florida, Texas, and the Southwest. But there are a lot of private pilots throughout the country. For many pilots, FAA BasicMed provides a simpler alternative, especially for those in rural areas where there may be FAA-designated aviation medical examiner shortages. But regardless, internists asked to complete the paperwork should take the evaluation seriously and check with their practice risk managers, administrators, or legal counsel to review the level of exposure a specific practice is willing to bear.
Thyroid Disease In The Aviator

There are approximately 3,100 active FAA designated Aviation Medical Examiners (AME). Each AME brings his/her expertise to the AME/pilot encounter. For example, a cardiologist/AME may readily detect a significant mitral insufficiency murmur that is missed by other examiners less skilled in auscultation. Similarly, if an examiner omits a portion of the exam such as palpation of the neck, significant thyroid disease can go undetected. Ask yourself, have you ever had your neck palpated during your flight physical? The presence of a goiter or nodule requires further evaluation that often leads to the detection of disease which directly impacts aviation safety. By illustrating several pilots I have seen during 40 years as an AME, I will show you the scope of thyroid disease encountered, and how it is best managed to keep the airman in the cockpit.

Thyroid disease is common in the United States. It is estimated that 6-8% of the adult population has a goiter, 4-6% has a palpable nodule, while 1-3% will develop hyperthyroidism, and 5-7% will develop hypothyroidism over their lifetime. Thyroid disease is 2-4X more common in females than males, yet we know that only 6% of active airmen are females. Thus, the majority of thyroid disease will be detected in male pilots. For example in 2014, there were 10,336 airmen with documented thyroid disease encountered, and how it is best managed to keep the airman in the cockpit.

54 Y.O. 3rd Class Private Pilot – 345 Hours
On my first encounter with this airman, he professed to have no problems, but my physical exam revealed a 50-60 gram asymmetric goiter that he acknowledged had been originally noted more than 4 years prior and had increased in size over the interim. He exhibited tracheal deviation to the right, but denied any compressive symptomatology. Review of his electronic medical record (EMR) demonstrated a recent serum TSH (2.8 mIU/L), and a CT performed 2 years prior revealed tracheal narrowing. Prior fine needle aspirations x2 revealed an atypical follicular lesion/neoplasm, and he had refused core biopsy or lobectomy despite continued goiter growth. As previously noted, a euthyroid goiter without compressive symptomatology is not disqualifying, but here we have the added concern of a possible malignancy. In our institution, this cytology category has a 30% likelihood of a papillary/follicular thyroid cancer. In this situation, the AME must defer the certification decision to the FAA. Subsequently, the FAA denied medical certification without clarification of the malignancy potential. Two years later, the airman developed a persistent cough that was relieved by left thyroid lobectomy that proved benign cytology.

58 Y.O. 1st Class A–T.P 13,825 Hours
When asked if there was anything new on his Medxpress form, this airman replied that it was unchanged from the prior. Having examined this airman at least 20 times, I was surprised to discover a new 2 cm palpable left lobe thyroid nodule. The likelihood of this nodule being malignant is 5-7% in our institutional experience. Our options are to complete the nodule evaluation within two weeks afforded by FAA regulations or to defer medical certification to the FAA initially, while the nodule evaluation ensues. A prompt evaluation was completed within 48 hours of his appointment. The appropriate nodule evaluation is shown in Figure 1. A serum TSH must be obtained first to determine the next test sequence. Most palpable nodules (99%) exhibit a normal TSH followed by a thyroid sonogram and fine needle aspiration (FNA). If the serum TSH is < 0.5 mIU/L, a radionuclide scan is ordered to confirm a benign autonomous functioning thyroid adenoma (hot nodule). This
airman’s sonogram confirmed a solitary 2 cm thyroid nodule with no suspicious features, such as hypoechoic, taller than wide dimension, intranodular vascularity, or microcalcifications. The FNA cytology was benign. If his sonogram had showed suspicious features despite benign cytology, it would be prudent to repeat the FNA in 1-2 years to exclude a false negative cytology. The airman was issued his First Class medical certificate and no further FAA follow-up was required. On subsequent exams, his nodule disappeared.

35 Y.O. 1st Class ATP/Naval Aviator – 450 Hours

This naval aviator was on a temporary duty assignment to his alma mater as a campus recruiter for naval aviation. When asked how things were going, he replied “Recruiting is tough”. He desired a renewal of his First Class medical certificate flying cargo for a local charterer. He had had a normal Naval flight physical two months prior. My exam revealed a palpable 2 cm left lobe thyroid nodule with no adenopathy. Using our nodule decision algorithm, his serum TSH was normal (1.2 mIU/L), his sonogram demonstrated a 2 cm hypoechoic nodule taller than wide and no abnormal regional adenopathy. His FNA cytology showed papillary thyroid cancer, and his medical certification was deferred to the FAA. As expected, my FAA deferral generated a prompt return FAA letter to the airman stating “Not able to determine eligibility for medical certification”. Subsequently, he was sent to Bethesda where a total thyroidectomy revealed a 2 cm papillary thyroid cancer, negative lymph nodes, and a post-op I-123 scan showed only benign tissue in the right neck. Six weeks post-op, his serum thyroglobulin (TG) was < 1ng/ml with negative TG antibody. His residual benign right neck thyroid tissue was ablated with 75 mCi of I-131 and he was started on levothyroxine 1.8 ug/kg daily and was euthyroid 6 weeks later. He was judged to be free of disease at 3 months, and a Special Issuance was granted at 6 months post-op.

34 Y.O. 2nd Class Commercial Pilot – 876 Hours

On this his second visit to see me, he denied any complaints. However, my exam demonstrated a 40 gram goiter, tachycardia with an irregular rhythm, lid retraction and a suggestion of proptosis. Further questioning elicited a history of a 10 lb weight loss over the past 3 months, excessive sweating, fatigue, nervousness, palpitations, and difficulty sleeping. There was a family history of thyroid disease, since his mother had been previously diagnosed as hypothyroid. My most likely diagnosis was Graves’ Disease, based on the goiter with signs and symptoms of hyperthyroidism. A serum TSH, FT4, EKG, and radionuclide scan were obtained the same day (Figure 2). His serum TSH was suppressed (< 0.1 mIU/L), his FT4 was elevated at 3.6 (normal range 0.5 -1.4), and his EKG showed atrial fibrillation with a ventricular rate of 124/min. To confirm the most likely diagnosis of Graves’ Disease, a Tc99m thyroid scan was obtained that demonstrated avid radionuclide uptake into the goiter with a thyroid/salivary ratio of 70% (24 hr. radioactive iodine uptake surrogate) indicative of Graves’ Disease. Surgery, anti-thyroid drug, or radioiodine are all effective therapies for Graves’ Disease. A total thyroidectomy or anti-thyroid drug therapy can usually render the patient clinically euthyroid within 4-6 weeks with radioiodine achieving the same in 8-10 weeks. Hypothyroidism ensues following surgery or radioiodine therapy and must be corrected by institution of levothyroxine therapy. The airman was started on Methimazole 15 mg, Warfarin 5 mg, and Metoprolol 50 mg daily and referred to Ophthalmology for evaluation. The airman’s hypothyroidism precluded medical certification and FAA deferral is required. The FAA responded “Not able to determine eligibility for certification” until euthyroidism is achieved. Methimazole and Metoprolol were stopped at one month and the airman was treated with I-131 and was hypothyroid at 3 months after the original diagnosis. He was then started on levothyroxine 1.6 ug/kg daily. His atrial fibrillation disappeared at 2 months post-diagnosis and his Warfarin was discontinued. The airman was euthyroid at 4.5 months and a Special Issuance was authorized at 6 months returning him to flight status with yearly serum TSH and Holter monitoring required. Six months later he was entered into the AME Assisted Special Issuance (AASI) program (Figure 4). Subsequently, the Holter monitoring was deleted from his Special Issuance.

48 Y.O. Corporate Pilot – 12,423 Hours

On this latest visit to see me, this airman offered no complaints. He had a past history of C-Pap-treated sleep apnea that was “cured” by successful mandibular advancement surgery, and his prior Special Issuance for Sleep Apnea had been rescinded. He stated that he continued on Fexofenadine and Omeprazole treatment for his allergic rhinitis and gastroesophageal reflux symptoms. My exam demonstrated that he remained obese (BMI 32), but was now tachycardic with systolic hypertension. He had no goiter or neck pain. Further discussion elicited the history of thyroid supplement ingestion obtained through the Internet for 6-8 weeks in the attempt to lose weight.
He had noted the recent onset warmth, thirst, and fatigue. His tachycardia and systolic hypertension suggested he was hyperthyroid. To evaluate this possibility, a serum TSH, and FT4 were obtained and confirmed hyperthyroidism (TSH <0.1 mIU/L and FT4 2.6 ng/dl). To confirm that his hyperthyroidism was most likely due to the thyroid supplement he was taking and not early Graves’ Disease, a Tc-99m scan was obtained. (Figure 5). To confirm that the thyroid supplement contained active thyroid hormone, chromatography analysis revealed that each tablet contained approximately 33 ug T4, and 3 ug T3. The pilot’s medical certificate was deferred to the FAA. His supplement was stopped and he was euthyroid 8 weeks later with FAA issuance of his medical certificate.

44 Y.O. 1st Class A.T.P. -11,230 hours

This was my first visit with this airman, who voiced no complaints when queried. My exam demonstrated a 40 gram firm goiter. Further questioning elicited no symptoms of thyroid dysfunction, and he was not aware of the goiter. He related that his mother had hypothyroidism.

To evaluate his goiter, serum TSH, FT4, and thyroid antibodies were obtained. He was found to have asymptomatic primary hypothyroidism with elevated TSH (27 mIU/L, low FT4 (0.4 ng/dl), and positive TPOab. A sonogram confirmed the goiter with the typical hypoechoic pattern of Hashimoto’s thyroiditis. The most current statistical handbook shows 10,336 airman with diagnosed hypothyroidism. The AME guide shows that 13 changes in documentation and disposition of hypothyroidism have occurred over the past 13 years. This airman’s disposition started a cascade of changes.

Since he was asymptomatic, FAA regulations at that time permitted me to initiate levothyroxine therapy and to issue him a First Class medical certificate. Much to my dismay, I discovered within a week that the airman had not started on his prescribed replacement therapy, since his mother had convinced him that a second opinion from her endocrinologist should be obtained before initiating such life-long treatment. Thus, I had issued a medical certificate to an airman with untreated primary hypothyroidism who was unlikely to start appropriate treatment anytime soon. I promptly contacted my Regional Flight Surgeon (RFS) to discuss the situation and to confirm that I had acted in accordance with AME guidelines. The RFS initiated an emergent revocation of the airman’s medical certificate. The airman was seen 5 weeks later by his mother’s endocrinologist who concurred with my diagnosis, and levothyroxine therapy was instituted. Three months later he was euthyroid and an Authorization for Special Issuance requiring yearly serum TSH monitoring was granted 2 months later. Shortly thereafter, the FAA required that an airman with newly diagnosed primary hypothyroidism must be deferred by the AME to the FAA for initial documentation and FAA-generated Authorization For Special Issuance after the airman is rendered euthyroid. On subsequent medical certification renewal visits, an airman could be medically certified through the AME Assisted Special Issuance (AASI) program as long as the airman provided a doctor’s statement reporting a normal serum TSH within the past 90 days and no adverse medication effects. This process of Special Issuance renewal was further simplified in April 2013 by the introduction of the CACI (Certificates an AME Can Issue) program that allowed an AME to issue a medical certificate directly to the airman as long as proper documentation was provided. Subsequently, further CACI updates eased the required serum TSH report to within one year instead of 90 days (Figure 6).

Summary

An abnormal thyroid gland to palpation is often the first clue to the detection of significant thyroid disease that requires further evaluation and/or treatment. A euthyroid goiter with no evidence of tracheal or esophageal compression is not disqualifying for issuance of a medical certificate. Palpable nodules almost always must be deferred to the FAA for further evaluation unless the nodule can be characterized as euthyroid and benign within the 14 day window between exam and required FAA submission. On occasion for a professional pilot, a direct conversation by the AME with a RFS may elicit permission to issue a first or second class medical certificate with the stipulation that the nodule work-up is completed within 90 versus 14 days. All forms of hyperthyroidism require FAA deferral, but the airman’s “downtime” can be significantly shortened by prompt initiation of the appropriate evaluation and treatment by the AME. Untreated hypothyroidism requires FAA deferral, but, again, prompt institution of therapy at the time of diagnosis facilitates the airman’s return to the cockpit sooner. Almost all airmen with treated hypothyroidism can be issued a medical certificate through the CACI program unless the airman is not euthyroid on replacement therapy.
Figures and Legends:

Figure 1. Palpable Nodule Decision Algorithm

![Palpable Nodule Decision Algorithm](image1)

Figure 2. Clinical Manifestations of Hyperthyroidism

![Clinical Manifestations of Hyperthyroidism](image2)
Figure 4. AME-generated report to the FAA confirming that the airman has met the requirements of his Authorization for Special Issuance and has been issued a time-limited Medical Certificate.

Certificate Issuance

I have reviewed the enclosed medical report(s) and have determined that the report(s) is in accordance with this applicant’s Authorization for Special Issuance of a Medical Certificate and the AASI Protocol established for certificate issuance.

Second

I have issued a Class Medical certificate to the airman named below with all other limitations listed on the original certificate. The certificate issued is timed limited by the restriction "NOT VALID FOR ANY CLASS AFTER ___________ ."

Date

Check all that apply:

Interim certificate issued for disease(s)/condition(s) below – No examination performed.

<table>
<thead>
<tr>
<th>ALL</th>
<th>AASI CONDITION</th>
<th>ALL</th>
<th>AASI CONDITION</th>
<th>ALL</th>
<th>AASI CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Colon Cancer</td>
<td>Diabetes Mellitus – Type II</td>
<td>Hypothyroidism</td>
<td>Malignant Melanoma</td>
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<tr>
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<td>X</td>
<td>Hypothyroidism</td>
<td>Hypothyroidism</td>
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<tr>
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<tr>
<td>Colitis (Ulcerative or Crohn’s)</td>
<td>Melanoma</td>
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</table>

Coronary Heart Disease
Figure 6. Updated CACI Work-sheet for Hypothyroidism that has been reviewed and completed by AME prior to medical certificate issuance.

**CACI - Hypothyroidism Worksheet** *(Updated 07/29/2015)*

The Examiner must review a current status report by the treating physician and any supporting documents to determine the applicant’s eligibility for certification. If the applicant meets ALL the acceptable certification criteria listed below, the Examiner can issue. Applicants for first- or second-class must provide this information annually; applicants for third-class must provide the information with each required exam.

<table>
<thead>
<tr>
<th>AME MUST REVIEW</th>
<th>ACCEPTABLE CERTIFICATION CRITERIA</th>
</tr>
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<tr>
<td>Treating physician finds the condition stable on current regimen and no changes</td>
<td><img src="true" alt="Yes" /></td>
</tr>
<tr>
<td>recommended</td>
<td>None of the following: fatigue, mental status impairment, or symptoms</td>
</tr>
<tr>
<td></td>
<td>related to pulmonary, cardiac, or visual systems</td>
</tr>
<tr>
<td>Symptoms and signs</td>
<td>![Levothyroxine sodium (Synthroid, Levothyroid), porcine thyroid</td>
</tr>
<tr>
<td></td>
<td>(Armour), liothyronine sodium (Cytomel), or liotrix (Thyrolar)</td>
</tr>
<tr>
<td>Acceptable medications</td>
<td><img src="true" alt="Yes" /></td>
</tr>
<tr>
<td>Normal TSH within the last one year.</td>
<td><img src="true" alt="Yes" /></td>
</tr>
</tbody>
</table>

**AME MUST NOTE in Block 60 one of the following:**

- CACI qualified hypothyroidism.
- [ ] Not CACI qualified hypothyroidism. Issued per valid SI/AASI. (Submit supporting documents.)
- [ ] NOT CACI qualified hypothyroidism. I have deferred. (Submit supporting documents.)
References:


Haugen BR, Alexander EK, Bible KC, et al. 2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer: The American Thyroid Association Guidelines Task Force on Thyroid Nodules and Differentiated Thyroid Cancer. Thyroid, Jan 2016: 1-133


www.faa.gov/go/oamtechreports

John E. Freitas, MD, received his undergraduate degree in 1967 from the University of Notre Dame, and his medical degree from the University of Michigan in 1971. He completed an Internal Medicine residency and a Nuclear Medicine fellowship at University Hospitals, Ann Arbor, MI. From 1974-76, Dr. Freitas served in the US Navy at NAS Miramar, San Diego, CA. He is a retired thyroidologist and Director of Nuclear Medicine Services for the St. Joseph Mercy Health System. He is a practicing AME, a Clinical Professor of Radiology at the University of Michigan Medical School and, for almost four decades, an active participant in medical student and residency education. Dr. Freitas is a long-time member of CAMA and also a member of the Flying Physicians Association (FPA), currently serving as the President of the Great Lakes Chapter. He serves on the FPA Board of Directors and chairs the FPA Samaritan Committee, where he has initiated close working relationships with Bahamas Habitat and other aviation service agencies involved with patient transportation and those working to meet emergency needs. Dr. Freitas and his wife, Beth, own a 1972 Beech Bonanza F33A, and he has over 3900 PIC hours and ratings for IFR, COMM, MEL, SEL, and SES.

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