***Part 67 application for replacement of a medical certificate***

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| 1. **Applicant Details**
 |
| First Names |       | Surname |       |
| CAA Participant ID |       | Date of Birth |       |  |
| Postal Address |       |
| City/Town |       | Postcode |       |  |
| Certificate Lost, Destroyed or Stolen |  Class 1 [ ]  Class 2 [ ]  Class 3 [ ]  |
| Certificate Holder’s Signature |  | Date |       |  |
| 1. **Application**
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| [ ]  | I am applying under CAR 67.65 for replacement of my medical certificate, which has been damaged**Please enclose the damaged certificate and mail with this application.** |
| [ ]  | I am applying under CAR 67.65 for replacement of my medical certificate which has been lost, stolen or destroyed **Please complete section 4 – Statutory Declaration.** |
| 1. **Application Fee**
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| Fee for replacement is $99 inc GST. The fee must be paid online at <https://sec.caa.govt.nz/onlinepayment>. Once payment is completed, an email notification with a receipt number will be sent to the email address provided |
| Receipt Number |       | Receipt Date |       |
| 1. **Statutory Declaration**
 |
| First Names |       | Surname |       |
| CAA Participant ID |       | Solemnly and sincerely declare that: |
| Please state why this application has been submitted |       |
| And I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957. |
| Certificate Holder’s Signature |  | Authorised Officer Signature |  |
| Declared at |  | Date |  |
|  |

Send the completed form and damaged certificate (where applicable) to:

Email: med@caa.govt.nz

Post: Aviation Medicine Team, PO Box 3555, Wellington 6140