Aviation Safety Committee Paper

ASC Meeting No. 55 – 14 February 2023
Canberra

Agenda Item:	**6**
Board Action:	**Decision**
Subject:	**Class 4 Aviation Medical Certificate Model**
Origin:	Policy proposal
Prepared by:	Client Services Centre – Aviation Medicine

Desired Outcome:

1. For ASC to endorse the progression of work towards the proposed Class 4 aviation medical certificate under Part 67 with a view to implementation by instrument in late 2023, prior to the making of the new Part 67, likely to be in late 2024 or 2025.

Executive Summary:

2. A self-declared aviation medical certificate under Part 67 of the Civil Aviation Safety Regulations (CASRs) is an important step in the modernisation of recreational aviation medical certification in Australia.
3. For safe and effective implementation in a timely manner, CASA Avmed, with industry support, proposes a Class 4 self-declared medical certificate using a fit-for-purpose standard that is supported by a suite of guidance materials and training for the pilot and their Specialist General Practitioner (SGP).

Background:

1. Over the past two decades, multiple stakeholders and participants in the Australian private and recreational aviation community have identified the importance of a self-declared aviation medical certificate. Stakeholders have sought alignment with other similar regulators including the Federal Aviation Administration (FAA), Civil Aviation Authority (CAA) United Kingdom, CAA New Zealand and Transport Canada. While each of these regulators' models has merits, none of them have the scope and flexibility that CASA is seeking. **Attachment A** details the differences in the key medical certification features of private and recreational type certificates, demonstrating the benefit of the CASA proposed approach.
2. Various approaches to self-declared medicals over the last two decades have been implemented external to Part 67 in an attempt to provide an accessible, flexible and safe recreational aviation medical certificate. These include the RAMPC, Basic Class 2 exemption and fitness assessments by Approved-Self Administering Organisations. Each of these have not been able to entirely deliver the desired outcomes, partly because they have not been supported by the comprehensive governance and implementation system that is provided with Part 67 medical certificates. As part of the reform of Part 67, a new "Class 4" self-declared aviation medical certificate is proposed to be formalised within the regulations, which will provide these extra layers of safety needed to support accessibility and flexibility.
3. The Aviation Medicine Technical Working Group has considered options based on broad industry consultation and expert advice and will continue to be involved in the development of Part 67. Earlier TWG discussions explored both Class 4 (SGP issued) and Class 5 (self-declared) options. The final recommendation was for a simpler approach using self-declared Class 4 within a strong framework of safety and quality assurance. The framework proposed by CASA AvMed to deliver this includes:
    a. development of a fit-for-purpose recreational aviation medical standard aligned with the private motor vehicle standards

b. comprehensive guidance materials for users of this standard for self-declaration

c. pathways for support of applicant decision-making by SGPs for more complex medical situations

d. focused training for SGPs with clear directions for application of the flexible recreational aviation medical standard, and

e. assurance of the safe and effective use of the Class 4 certification process through CASA audit, oversight and referral pathways.

4. CASA's approach will mean that the pilot's assessing SGP will be able to apply a more flexible standard and make this certificate accessible even to pilots with medical conditions of a type or severity that may be excluded by the jurisdictions listed above. The proposed pathway for the Class 4 medical certificate is outlined in **Attachment B**.

5. Operational considerations are critical to the safe implementation of the Class 4 license and medical certificate. Judicious use of operational restrictions will balance the increased acceptance of medical risk, to achieve an optimal outcome that permits the majority of recreational pilots to undertake the majority of recreational activities. The nature of the medical standard and the scope of permitted operations will be informed by a new Technical Working Group appointed by CASA's Aviation Safety Advisory Panel. TWG recommendations will be sought on elements including the risk thresholds for medical and operational restrictions, approach to self-assessed and medically reviewed aeromedical risk assessment and certification, and regulator audit/oversight functions.

6. Second-order benefits of the Class 4 model include the potential transfer of significant numbers of private pilots from Class 2 across to Class 4, opening capacity for CASA and authorised Designated Aviation Medical Examiners and non-CASA aerospace medicine specialists to issue and review Class 1, 2 and 3 certificates. CASA will also be ready for a likely move by ICAO towards a recreational aviation medical certificate.

7. Introduction of the Class 4 medical certificate with its supporting guidance materials will deliver an important outcome for the recreational aviation community. Delaying introduction until the making of the new Part 67, likely to be in 2024-2025, will not provide any additional benefit from a safety or legislative perspective, but will erode confidence and goodwill within the industry. It is therefore proposed that the Class 4 medical certificate standards, guidance materials and implementation package will be developed in early to mid-2023 with implementation by instrument in late 2023 before incorporation in the new Part 67 in subsequent years.

Recommendation:

It is recommended the ASC **approves** the development of the proposed Class 4 recreational medical certificate guidance materials and standards, to support implementation by instrument in 2023.

Proposed Resolution:

The ASC **approved** the development of the proposed Class 4 recreational aviation medical certificate and supporting governance systems and policies, for implementation by instrument in 2023.

Prepared by: Dr Kate Manderson, Principal Medical Officer

Approved by: Andreas Marcelja, EM SED

Date: 9 February 2023

Attachments:

A Class 4 Comparison Tables

B Class 4 Pathways to Certification

Contents

Overview

Part 67 of the *Civil Aviation Safety Regulations (CASR) 1998* sets out requirements relating to medical certification, designated to aviation medical examiners and designated aviation ophthalmologists.

Regulations relevant to medical certification includes appointment of examiners medical standards, issuing and renewing certificates and suspending and cancelling certificates This regulation affects:

- designated aviation medical examiners (DAMEs)
- designated aviation ophthalmologists (DAOs)
- pilots
- air traffic controllers

In 2018 CASA introduced a range of changes to the aviation medical certification system by a legislative instrument: These changes included creating a new category of private pilot medical certificate (Basic Class 2) which could be assessed by a general practitioner against the commercial driver standard, additionally enabling:

- a Class 2 medical for pilots operating commercial flights that do not carry passengers (up to a maximum take-off weight of 8618 kilograms)
- all DAMEs to have the option to issue Class 2 medical certificates on the spot, in most circumstances

Introduction

This consultation was conducted between 2 May and 12 June 2022), with the aim of exploring measures to simplify and modernise CASA's overall approach to medical certification.

CASA used its online Consultation Hub to gather data on the following 6 broad focus areas:

1. review Part 67 to ensure it is up to date and fit for purpose
2. assess the implementation and outcomes of Basic Class 2 medical certification
3. review the effectiveness of CASA delegations to DAMEs and whether these could be extended or improved, or whether DAMEs can be given direct authority under the regulations to issue medical certificates
4. consider other areas of aviation activity where medical certification could improve safety outcomes
5. establish whether the current structure of medical certification for recreational aviation is fit for purpose
6. consider any other relevant medical matters

Additionally, feedback is also being sought on 3 key potential reforms that CASA are considering:

1. self-declared medical for private pilots
2. building the principles underlying the Basic Class 2 medical certificate into Part 67 and simplifying the medical certification structure
3. empowering DAMEs to do more by expanding delegations.

Most of the data collected via this consultation was qualitative feedback, with quantitative data limited to the provision of information about demographics and self-identified aviation roles. Respondents were given a text box with no restrictions to offer their opinions and suggestions. This provided an opportunity for respondents to elaborate on ideas. A Fact Bank was provided for each policy topic to highlight significant matters that should be considered prior to responses. Responses were then analysed in terms of common themes and issues for consideration.

Respondents

CASA received 611 responses through the Consultation hub. Where consent to publish a response was provided, these have been published on the Consultation Hub.

68% of respondents consented to having their responses published and 32% requested their responses remain confidential but understood that de-identified aggregate data may be published. 2 respondents were CASA officers. Multiple selections were permitted (for example, a respondent might be both a DAME and a drone operator). Table 1 summarises the majority responses, and Figure 1 demonstrates the full range of responses.

The majority responses were in the following categories:	
Pilots	85%
Amateur/kit-built aircraft owners	25%
Sport aviation operators	18%
Selected one or more groups	11%
Organisations	10%
Identified as “other”	5%
DAME	2%
No category selected	3%

Table 1: Majority respondent categories

Respondents who indicated that their role was that of an organisation, where multiple stakeholder views may be represented by one submission, number 60 or 10% of responses. The nature of the organisation (such as industry representative group, flying club, private company) was not identified.

The pilot population was not further analysed in terms of type of operations (Air Transport (ATO), Airwork (AWK) or General Aviation (GA)). The data was not further analysed in terms of which respondents were more likely to indicate a certain position on each theme; only the pooled data was reviewed for each theme and question.

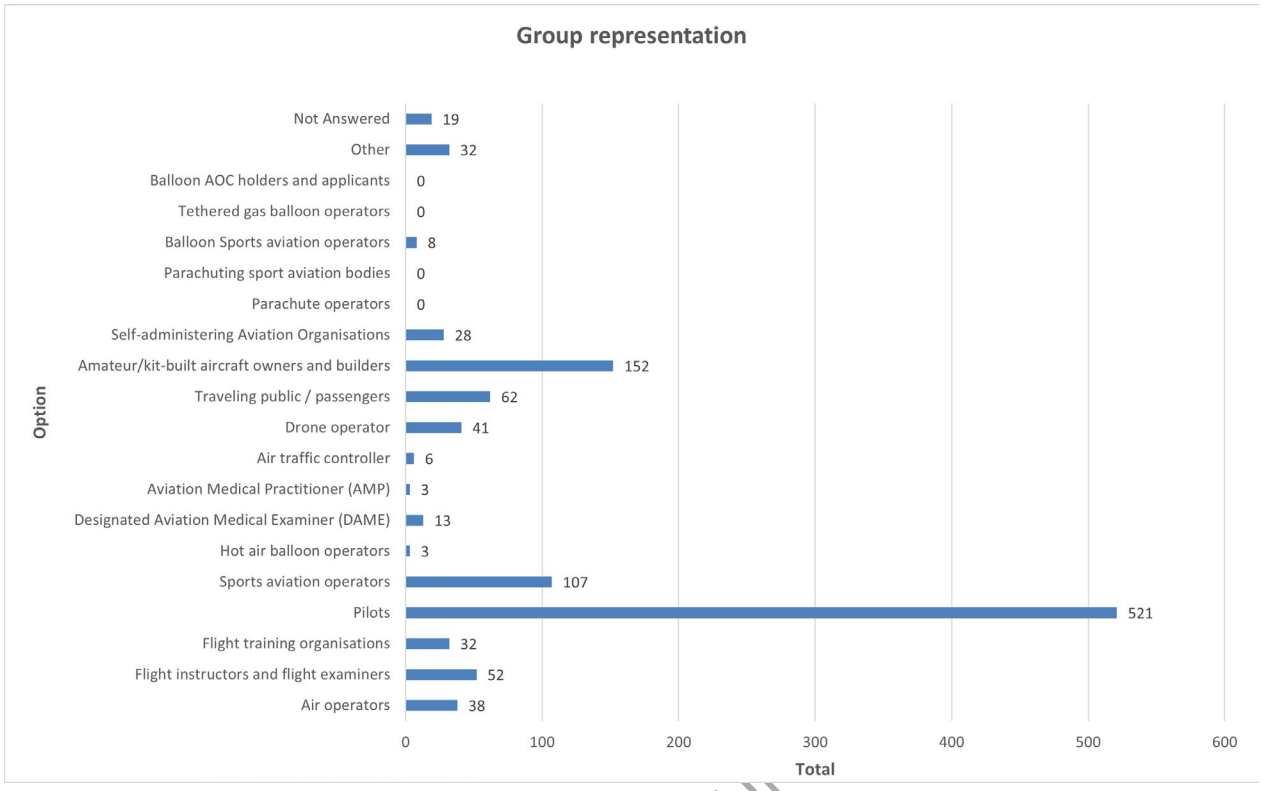

Figure 1: Consultation sector responses

Summary of Responses

Across all topics and responses, the following themes were consistently reported. Many of these themes are interconnected, for example a medical certificate issued by a doctor outside CASA (process) that requires a more detailed medical examination and doctor training (standards) will increase the cost to the applicant of seeing that doctor (access).

Access – consideration of the financial, time and effort cost to applicants of undergoing the medical examination or assessment.

> *Decentralise as much as you can for all non-exceptional cases. Limit the exceptions to the real risk areas. Use GPs and other specialists as part of the decentralised model much more. They understand a patient's history far better than any other physician possibly can at a consultation every 2 years.*

Process – desire to reduce complexity and bureaucracy, to have a simplified process that still provides an assessment that is appropriate to the level of risk, and in general to reduce the involvement of CASA in direct decision-making.

> *I consider DAMEs, who are assessed by CASA to be suitable and are conversant with the CASA standards be judged competent to issue Class 2 medicals. At present there are too many levels of administration. Not allowing DAMEs to fully assess and where appropriate issue a Class 2 medical tends to show distrust of appointed DAMEs competence.*

Standards – what standard is being applied, at what level, for what kind of operations, by what medical examiner, with what level of oversight.

> *CASA should listen to the message from aviation industry organisations. Industry organisations all want the industry to prosper and have no interest in promoting safety standards that might undermine its future prosperity.*
>
> *From a safety management perspective, industry organisations strive for safety outcomes that are consistent with CASA's objectives.*

Safety and risk – consideration of the need for checking compliance with the relevant standard through a process of quality assurance to ensure safety, balanced with the risk of the aviation activity.

> *A decentralised model that doesn't include overly complex audit, and quality assurance investment. Whilst the TWG considerations of guidance, training and resourcing are all valid, overcomplicating the system with the introduction of invasive audit/ assurance*

requirements will mean many DAMEs opt out of the scheme, negating any benefit of it. DAMEs still have a far greater understanding of complex case matters than CASA medical personnel; they are hands on with the patient, understand the history and are better placed to make assessments.

Evidence – experience of other jurisdictions, and the use of Australian and other data to inform decisions on individual certificate requirements and the certification system.

CASA's "additional guidance" is inappropriate. CASA should accept the approaches of other competent jurisdiction. One of the risks for CASA is that its AvMed staff may feel threatened by these changes.

Key feedback

Theme 1 - Medical certification structure

Topic 1a: Assess the implementation and outcomes of Basic Class 2 certification and of other changes to the Class 2 certification process

Overview

In 2018 CASA introduced a Basic Class 2 medical certificate (BC2MC) . To enable this alternative medical certification pathway, an Exemption Instrument was provided EX69/21

Respondents were asked to consider how to incorporate the Exemption Instrument BC2MC principles into Part 67.

FACT BANK: Concept for simplified medical certification structure

A revision of the medical certification structure could present a logical sequence with decreasing levels of CASA involvement, offset by increasing conditions and restrictions:

- Class 1 (no change): examined by DAME, reviewed by CASA on Class 1 medical standard; possible renewal by DAME if non-complex
- Class 2 (no change to standards but streamlined processes): examined by DAME, reviewed by CASA only for cases of irreversible dementia, psychosis, or epilepsy or by DAME request, issued on Class 2 medical standard
- Class 3 (no change): examined by DAME, reviewed, and issued by CASA on Class 3 medical standard for Air Traffic Controllers
- Class 4 (replaces Basic Class 2): examined by DAME/or medical practitioner. Exploring whether this could be issued on unconditional Austroads commercial guideline (this is the same guideline as that applied to medicals for commercial truck drivers) or a new guideline developed by CASA (informed by approaches of other jurisdictions).
- Class 5 (new): self-declaration on Austroads private motor vehicle standard guideline issued by self-administering organisation or CASA

Question 1 - What do you see as issues and risks for using the Austroads standard (with additional guidance for medical practitioners to help with interpretation and decision making)?

Response themes

65% of respondents advised that they felt there were no or minimal issues and risks in adopting the Austroads standards, and 25% indicated that they felt there were issues and risk. The common themes across this feedback included:

Costs: The cost to the applicant should be considered, as it may be increased.

Process: The time taken to have the medical completed may be reduced if it becomes a simplified and more streamlined process with less involvement of CASA.

Compliance: Pilots may not declare their medical conditions, and there may be more medical events in pilots under these standards.

Standards: Suitability of the Austroads standards for the aviation environment should be considered. Additional guidance may need to be provided for medical examiners and pilots as medical practitioner may not be familiar with the standards themselves and how to apply the standards for aviation.

Risk: There may be increased safety risk relating to issues around compliance and standards, however the experience of other jurisdictions indicates that risks to aviation safety may not be significant.

There are very limited risks or issues using Austroads as the basis for BASIC CLASS 2 type of licence. There sufficient protection in the UNMODIFIED Austroad examination

As long as it simplifies the current medical system then I see no problem

The GA sector has been calling for reforms to medicals for many years. I can only see upsides.

No issues really, there may be a small increased risk for underlying and undetected heart conditions. Maybe an ECG should be conducted just for the initial.

Question 2 - What do you see as issues and risks if CASA was to develop a new guideline informed by the approaches of other jurisdictions?

Response themes

61% of respondents advised of no or low/minimal issues and risks, while 28% identified some issues and risks. The common themes across this feedback included:

Benefits: Using the experience and resources of larger populations and jurisdictions means CASA doesn't need to create our own version, as other jurisdictions' guidelines are already in use with no clear safety implications.

Issues: CASA may be overly conservative in developing the new guidelines. Introducing more guidelines may introduce complexity, confusion, and additional cost in choosing which standard applies to whom. Implementation would require the applicants and practitioners to understand the process for it to be effective.

That sounds like a sensible approach. The only comment I'd make is that Australian airspace is generally very much less crowded than in the UK (for example), and that needs to be taken into account. In particular

The risk is CASA will cherry pick the most restrictive components from other jurisdictions and amalgamate them into claimed 'world's best practice' as it has done with airspace, among others. Resist the desire to over-regulate and introduce a homogenous and practical evidence-based solution.

As long as it simplifies the current medical system then I see no problem

There is no risk, as demonstrated by both the US and UK examples.

The experience of the FAA, which oversees many more pilots than any other aviation regulator in the world, has not demonstrated any increased risk by adopting driver's licence-based standards for private pilot medicals. There are no other obvious risks in such an approach, and many benefits - reduction in CASA workload, reduced cost to pilots, revitalisation of the recreational aviation industry.

Topic 1b: Austroads levels

Overview

The Australian Driver's License Standards have been published in the document "Assessing Fitness to Drive" (AFTD), produced jointly by the National Transport Commission and Austroads, as an element of the Safe System approach of the National Road Safety Strategy. The private and commercial medical standards in this document are used by medical practitioners in each State to recommend to the licensing authority whether the driver is fit to drive, including whether the medical practitioner or licensing authority might apply any conditions to the license (for example, need for extra or regular tests, yearly medical examination, or restriction on the type of vehicle or type of driving).

In general terms, the driver's license standard (both private and commercial) allows for drivers to continue to drive without restriction, even when they have some diseases or medical problems. This is the "unconditional driver's license".

With certain diseases, or higher severity of some diseases, the driver (both private and commercial) may be required to see a medical practitioner to review their medical fitness to drive every year and may have some other restrictions. Some restrictions are on the recommendation of the medical practitioner completing the driver's license medical assessment, and some are at the direction of the State driver's license authority. This is the "conditional driver's license".

The diseases, severity and restrictions that allow unconditional and conditional licenses are less restrictive for private drivers, and more restrictive for commercial drivers. Each State licensing authority also has some discretion as to what medical reviews and restrictions are required for private and commercial driving in their State.

The ability to include conditions on an aviation medical using driver's license standards is a subject for discussion. Currently CASA advises applicants, as the Basic Class 2 is fundamentally the *unconditional* Austroads standard, that if they do not pass the Basic Class 2 medical, or have a pre-existing medical condition, then they should approach their DAME for a full Class 2 assessment, as DAMEs have more flexibility to consider the specific circumstances in an aviation context and manage certain medical and or pre-existing medical conditions. The BC2MC as applied by CASA does not currently extend to this option to include conditions, hence a subject for discussion.

Question 3 - Considering the above which of the following options would work best?

1. A potential Class 4 certificate should bring the unconditional Commercial Austroads standard from Basic Class 2
2. There should there be flexibility to allow for a conditional issue against this standard by a GP
3. The Private Austroads standard should be considered for the Class 4 noting the unconditional application of the Commercial Austroads standard for Aviation use can be a stricter standard to meet when compared to the conditional application of a Class 2 Medical.
4. Other

Response themes

In order of popularity, respondents selected:

Option 2: Flexibility to allow for a conditional issue against this standard by a GP (32% of respondents).

Option 4: Other (29%)

Option 3: Private Austroads standards should be considered for the Class 4, noting the unconditional application of the commercial Austroads standard for Aviation use can be a stricter standard to meet (18%)

Option 1: A potential Class 4 certificate should bring the unconditional commercial Austroads standard from Basic Class 2 (12%).

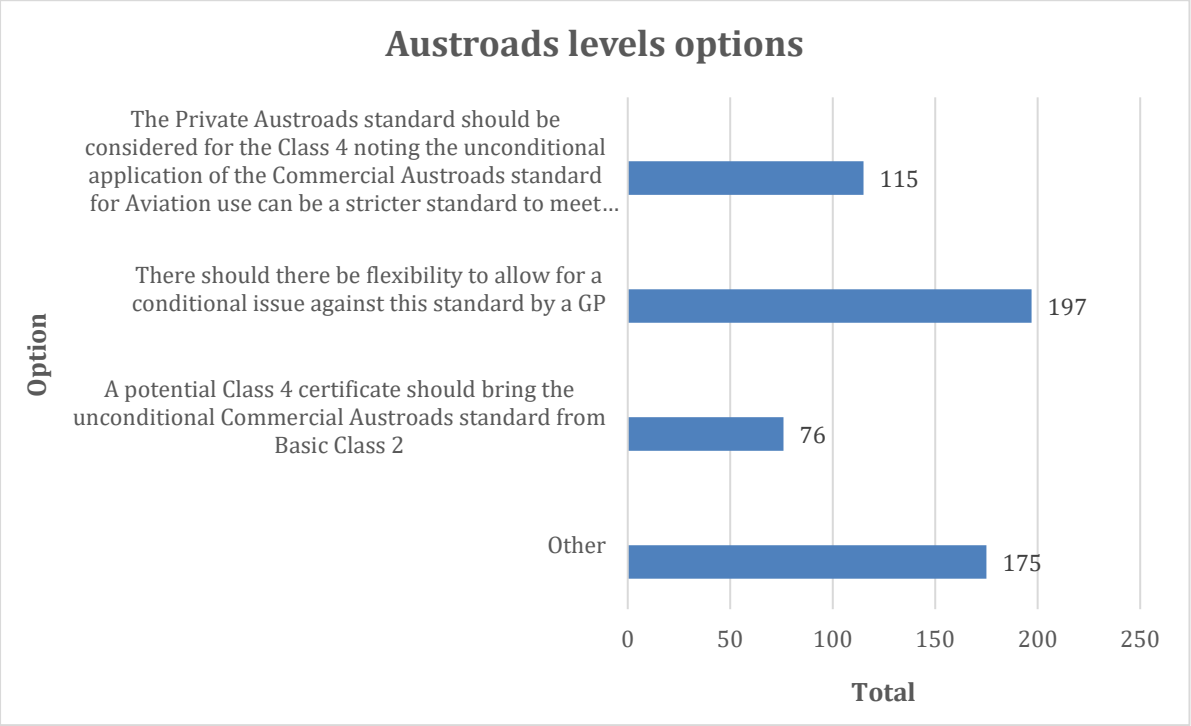

Figure 2: Austroads levels options

Commentary provided with these responses followed the following themes:

Operational restrictions: The nature of flying under the proposed certificate should be considered when choosing the medical standard (aerobatics, IFR, passengers, aircraft size and type)

Self-declared medicals: The use of the Austroads standard should be considered for a self-declared medical

Medical and examiner standards: The level of medical qualification required for certification should be matched with the level of the certificate and the standard being applied (Self, GP or DAME, ASAO, Class 1-5). The training and performance of the doctors

performing the assessments will need to be considered. The suitability of the standard being used should be considered, making sure it is appropriate to aviation.

Process: The approach to driver's license-based aviation medical certificates used in other jurisdictions should be considered. The process should be simplified, with less CASA involvement.

A potential Class 4 certificate should bring the unconditional Commercial Austroads standard from Basic Class 2

There should there be flexibility to allow for a conditional issue against this standard by a GP

The Private Austroads standard should be considered for the Class 4 noting the unconditional application of the Commercial Austroads standard for Aviation use can be a stricter standard to meet when compared to the conditional application of a Class 2 Medical.

Theme 2 - Expanding DAME delegations

Topic 2 - Determine the effectiveness of CASA delegations to Designated Aviation Medical Examiners (DAMEs) and whether these could be extended or improved.

Overview

As part of the review, CASA is exploring whether to extend DAME delegations and what training DAMEs would be required should proceed. Early feedback on this highlights that further DAME discretion would increase their time and financial commitments. It has been suggested that a decentralised model would need to be collaborative between DAMEs and the CASA and suggests DAMEs should have the ability to opt in or out of issuing certificates.

Fact bank: Further information about the current DAME system

Part 67 enables CASA to appoint appropriately qualified persons as a DAME/ DAO (designated aviation ophthalmologist) or a Credentialed Optometrist. Currently a DAME may issue a Class 2 medical certificate to an applicant if the DAME holds a current instrument of delegation from CASA and complies with the conditions and limitations set out in the DAME Handbook. To undertake a Class 2 medical assessment the DAME must complete the Medical Assessment Report in CASA's Medical Record System (MRS) which identifies the conditions, their safety- relevance, and the certification decision.

If a DAME has any concerns about an applicant meeting the relevant medical standard, they must refer the matter to CASA for determination.

CASA considers that the DAME system has worked well, and the MRS system has improved both the effectiveness and timeliness of the issue of medical certificates.

Fact bank: Technical working group (TWG) considerations

- The TWG considered the proposal for an expansion of CASA delegations to DAMEs to further decentralise the current model.
- The TWG reviewed the proposal for DAMEs to issue Class 1 and Class 3 certificates without CASA being involved in the process unless required when being referred complex cases. The TWG added that issuing Cl 1 and Cl 2 medical certificates should be available for DAMEs that are interested and qualified, with oversight conducted by CASA. TWG also emphasised the importance of strong investment in training, audit, and quality assurance to allow for a more decentralised model.
- The TWG discussed challenges associated with delegation, including complex case management, the potential for inconsistency in decision making by delegated DAMEs, and financial considerations such as fair compensation for DAMEs conducting full examinations. The TWG acknowledged that inconsistency of outcomes will always be apparent, however noted that consistency in approach can be safeguarded with appropriate resources e.g., up to date current medical manual and training and Medical Records System (MRS) design as an additional safety measure (rules engines that recommends when CASA should be involved).
- The TWG discussed CAA NZ's decentralised model. It was suggested that a decentralised model would need to be collaborative between DAMEs and the CASA, particularly for complex case management. The TWG also discussed providing DAMEs with the flexibility to opt in or out of being delegated to make assessments to issue certificates. In general, the approach taken should be less CASA involvement in routine decision making and a supported DAME network who have the confidence and skills to issue routine medical certificates for a variety of low-risk medical conditions and by way of accredited medical conclusion and support for CASA complex medical cases where appropriate.
- The TWG emphasised the importance to ensure there is appropriate and sufficient guidance, training, and resources for any expansion of delegations to DAMEs. It was also noted that CASA will need to have sufficient resources for DAMEs to cater for the resultant increase in oversight and training requirements.

Question 4 - What other things do you think we should explore to extend or improve DAME delegations

Response themes

28% of respondents did not make a comment, noted that they had nothing to add, or indicated that they were satisfied with the current DAME delegations.

Of the remaining 62% of respondents, common themes are listed below. Of note, 60% of comments (328 of the 551 who provided a response) indicated a desire for DAMEs to have expanded authority and responsibility for issuing medical certificates.

Expansion of DAME delegations: DAMEs should be empowered in decision-making and issuing certificates, with responses ranging from full authority to issue in all cases to DAMEs having limited authority to issue based on the medical situation.

> *Absolutely give DAMES the authority to issue a medical! Casa should be issuing to all dames the requirements and that's it. Cost effective and efficient.*
>
> *Allowing initial issues of medicals*

Variation of DAME authority: matching the authority of the DAME to issue the certificate, and the involvement of CASA, with the Class of the medical certificate.

> *I do like the idea of DAME's been able to issue class 1 medical certificates as they physically see the applicant and generally also know the applicant where as CASA reviews the application but doesn't see the applicant.*

GPs and treating doctors: The responses ranged from allowing non-aviation treating doctors (GPs and other Specialists) to make the decision about medical certification without involving DAMEs or CASA, to allowing DAMEs to make final decisions based on GP and other Specialist advice.

> *If a Pilot is using his own GP then that GP Knows his History.*
> *A Pilot should not go to a New GP that has no knowledge of Past issues, So The GP should have to state that he has been Treating the Pilot for some time.*
> *Knows His History. When We go to a DAME they Do not know our History, only what we tell them.*
>
> *My GP has been looking after my health he knows all about my health and his opinions should be enough to issue a PPL medical*
>
> *DAME don't do anything but administration for CASA a normal GP could do the same and at least your GP knows the pilot/patient*

CASA's involvement: Responses included avoidance of CASA's involvement in medical certification altogether; only referring complex cases to CASA for decisions; or CASA's involvement being limited to quality assurance.

Simplify the whole process. I have had several DAMEs I know of state the additional bureaucracy required in dealing with CASA at all makes it difficult to justify them remaining DAMEs and the degree of oversight of CASA on the DAMEs when the DAMEs are the experts on the medical issues involved makes the whole process unnecessarily difficult, costly, and time consuming and moreover, does not add value at all.

Theme 3 - Self-declared medical for private pilots

Topic 3 - Review other areas of aviation activity where medical certification could improve safety outcomes

Overview

CASA is considering a self-declared driver's licence medical certificate for recreational pilots to be regarded as a Class 5 medical certificate under the revised certification structure outlined in Topic 2.

A self-declared medical would provide an alternative and easier pathway than the current Basic Class 2. It would encourage greater participation across the industry and is an initiative in our GA workplan to encourage growth of the sector.

Fact bank: Technical working group (TWG) considerations

- The TWG discussed how a Class 5 self-declared medical certification would be administered and whether it would place additional (and replicated) requirements for aviation self-administering organisations (ASAOs) that operate under CASR Part 149, such as RAAOs.
- The concept discussed was for CASA to set guidance for a self-declared medical certificate which is governed under CASR Part 67 and would allow certain organisations to continue to manage their own medical certification processes. In this instance, CASA's role would be to approve the processes and audit the organisation.
- Discussions also covered concepts for how ASAOs would continue to manage their assessments of self-declared medicals via their operations manuals through Part 149. The audit, compliance, and oversight role of CASA for Part 149 organisations includes all elements of the ASAO's operations, which extends to the processes used by the ASAO for medical assessments and standards. CASA Avmed would work with the ASAOs to support their medical assessment processes to be safely and effectively managed under part 149, and for ASAOs would continue to be independent from the medical certification requirements for Part 67.
- The TWG considered introducing a Class 5 self-declared medical for VH-registered aircraft. The TWG discussed that the certification may be based on the Austroads private motor vehicle driving guidance. It was also noted that if the individual did not meet certain criteria, they would need a doctor to assess and issue the certificate and that CASA would need to provide guidance to support. CASA would also have an oversight and audit capability.

Question 5 - What do you consider to be the benefits of the Class 5 medical certificate concept?

Response themes

8% of respondents advised that they felt there were no benefits, and 85% of respondents identified benefits. The major theme for Question 5 responses was around improved and expanded access and availability: Class 5 would allow increased access to medical certificates for pilots based on reduced financial cost of the medical assessment; the Class 5 would be of reduced complexity and allow faster issuance of certificates. The self-declared Class 5 would be a more flexible standard, which would mean more people could have a medical certificate.

Less red tape. Less stress on pilots. Will assist in reinvigorating GA.

The Class 5 medical would have to have limitations on flight abilities for the license holder like the Basic Class 2 and as its naming suggests being a lower class than the Class 4

medical. For flight training this could be very beneficial to get people into the industry and to give them a taste of flight training before committing hundreds to complete a Class 1 or 2 medical. However strong auditing will be required. I also suggest having this done by a web form, probably MRS, for people to submit their medical information for casa to easily audit. It can also be cross checked against other discrepancies in an automated function

This change would free us from the oppressive and invasive decisions frequently made by Avmed, which have driven so many competent pilots out of the industry. It would put an end to the stressful and expensive unnecessary tests that Avmed arbitrarily require, against the advice of specialist medical practitioners.

This change would free up Avmed resources to work on things that matter more - commercial operations.

Question 6 - What do you consider to be issue and risks regarding the Class 5 medical certificate concept?

Response themes

54% of respondents advised no or low/minimal issues and risks, 36% of respondents identified issues and risks, with the remainder providing no response or indicating that they had no opinion.

Common themes included:

Safety: A self-declared Class 5 certificate may increase risk through non-compliance with self-declaration, where pilots with significant medical issues may not declare them. There may be increased risk due to permitting more pilots with complex medical conditions to fly.

Standards: There may be increased complexity or potential confusion over which standard applies to which pilot. A process for oversight should be considered to ensure standards are being applied correctly.

Operational considerations: A self-declared Class 5 certificate should consider the nature of the flying operations (aircraft type and registration, airspace, size, number of passengers, licence endorsements).

Access: Issues around levels of bureaucracy and administrative burden for pilots and organisations of administering a Class 5 self-declared model should be considered.

There is risk no matter what but let us de regulate as other countries have done. This will allow the dying GA and Rec to grow.

CASA will find it hard to relinquish control and I believe that any potential issues will be raised as complex cases and end up being a more involved, complex outcome for the individual

The road traffic data suggests very few incapacitations' episodes

No additional risks.

The RAA has shown this to work, and there is no reason that a private pilot flying a VH registered aircraft should have to have any higher standard than a pilot flying an RAA Registered aircraft.

In fact, there is no reason why he/she should have any higher standard than a car driver - who is likely to cause far more damage if he takes ill at the wheel of his/her car."

Theme 4 - Standards for drone pilots

Topic 4 - There are no current Australian medical standards in respect of remotely piloted aircraft operations. This is an area for future policy consideration, and we would like your ideas early.

Fact bank: Technical working group (TWG) considerations

- The TWG discussed the considerations associated with remotely piloted aircraft (RPA) operations. It was raised that the weight of the RPA and the type of operation being conducted may be appropriate parameters to consider whether medical certification would be relevant – such as through a matrix.
- The TWG considered the concept of a Class 3R medical certificate for higher risk operations, and no medical certification for lower risk operations (as opposed to staggered certification based on operational risk).
- The TWG discussed the levels of redundancy and on-board capability of RPAs in the context of loss of control or possible medical episodes causing a flyaway drone. It was noted that type certified RPAs have requirements for specific on-board capabilities, and that similar capabilities are generally found (but not required) for RPAs weighing 25kg and over.
- The TWG discussed the need for further information, such as the rate of failure for RPAs and further consideration of the risk level in the context of RPAs weight (e.g. 25kg vs 150kg).

Question 7 - Do you think there are any aviation medical considerations that should be considered for pilots of remotely piloted aircraft systems (e.g. drone size, category, type, distance flown, type of operation)?

Response themes

21% of respondents said there should be no aviation medical considerations for pilots of remotely piloted aircraft systems, while 58% of respondents agreed there should be considerations for pilots of remotely piloted aircraft systems. The remainder either provided no response or indicated that this did not have a position on this question.

The responses were around two major themes, related to the medical standards, the nature of operations, and how these should be matched in considering a drone operator medical standard. Higher risk operations (commercial, controlled air space, passenger carriage, larger drones, higher altitude, outside line-of-sight) should be considered for a medical standard, while lower risk operations may have a lower medical standard or no medical standard. Respondents also indicated that CASA should consider the approach of other jurisdictions.

Drones that pose a significant safety risk because of size or area of operation etc should be operated by persons that meet a minimum health standard
Perhaps basic class 2

Given the automation and intelligence of modern drones, I'm not sure the health of the operator plays any real part

No, most heavy drones have multiple levels of redundancy that reduce risk in any event of operator incapacitation. CASA does not need to be involved in any way.

Theme 5 - Flight instructors in sport and recreation

Topic 5 - Establish whether the current structure of medical certification for recreational aviation is fit for purpose

Overview

Given the importance of flight instructing as a keystone of aviation safety, it is appropriate to explore whether the general practitioner endorsement of the medical status of an instructor in the sport and recreational sector is a sufficient level of medical clearance.

Fact bank: Current medical requirements for flight instructors

Under the flight crew licensing rules (Part 61 of CASR) a flight instructor involved in flying training must hold a private, commercial or air transport pilot licence, and the relevant medical certification to enable the exercise of the privileges of their licence. An instructor in the sport and recreational aviation sector is required to hold a higher medical standard than that of recreational pilots. For example, Recreational Aviation required minimum for an instructor is a CASA Class 2 Aviation Medical Certificate or higher, or RAAus Medical Questionnaire and Examination form completed by the candidate's General Practitioner. The Gliding Federation of Australia also requires instructors to maintain their Medical Practitioner's Certificate of Fitness.

As with other forms of aviation, instructor incapacity contributing to incidents and accidents in the sport and recreational aviation sector is rare. However, given the importance of instructing as a keystone of aviation safety, it is appropriate to ask as part of a review of Part 67 whether the general practitioner endorsement of the medical status of an instructor in the sport and recreational sector is a sufficient level of medical clearance.

For example, Transport Canada's category 4 medical certificate which is primarily for recreational, ultralight and glider pilots, requires glider and ultralight Instructors to provide a medical report within five years of issue or revalidation regardless of age, and for those over 40 need an ECG at first examination and every five years thereafter. However, pilot incapacitation remains an uncommon event and while instructor incapacitation does happen (as was the case at Jandakot in August 2019 where the student pilot needed to land the aircraft after the instructor became unconscious) such an occurrence is even rarer

Fact bank: Technical working group (TWG) considerations

The TWG questioned whether a higher medical standard for instructors would provide extra safety outcomes.

Question 8 - Should a higher level of medical certification (e.g. a CASA Class 2 medical certificate) be required for flight instructors in the sport and recreational sector?

Response themes

Where a response was provided (from 86% of respondents), slightly more indicated a desire for a higher medical certificate for sport and recreational examiners than those who felt the medical standard should not be different to for the instructor and the student – 47% for a higher standard compared with 39% for the same standard. Common themes in these responses included:

Evidence: The decision on whether a higher medical standard is required for instructor compared to student should be based on data around medical incapacitation of instructors. The experience and approach of other jurisdictions should be considered.

Access: The impact on availability of instructors if higher medical standards are required should be considered.

Risk: The instructor medical standard should be matched to the level of risk and the nature of instruction (considering experience, flight profile, aircraft factors). This should inform what medical standard should be applied (such as self-declared, Austroads, or Part 67).

Yes. Considering that they are taking a paid student onboard and are entrusted with their safety, it is only reasonable that these instructors hold a higher standard of medical, as opposed to just self-certifying. They need to be fit and healthy enough to prevent a student having an accident and to take control in the event of an emergency. Considering the low hours many recreational pilots may have and the nature of low inertia high drag aircraft, it is only reasonable that instructors in recreational aviation are held to a higher standard.

yes, the demands and stresses associated are higher than a typical recreational or private operation and therefore the risk is higher. I do however believe the current class 2 would be more than enough to satisfy the risks

All flight instructors should hold a class one medical based on the increased risk when flying student pilots.

Theme 6 - Modernising the rules

Topic 6 - Examine the Part 67 regulation to ensure it is up to date and fit for purpose

Overview

The Part 67 rules contain significant amounts of outdated material and information that, if it were being drafted now, would properly belong in a Manual of Standards (MOS) and advisory documents, rather than in the regulation itself.

Placing certain provisions in guidance material e.g. DAME Medical Manual will make it easier to change and update than having it in regulations. This will allow us to keep pace with advances in medical practice and the evolution of aviation medical regulation.

We understand that regulations can be difficult to read, so we plan to make it easier for you in the future by publishing a Plain English Guide to Part 67. It will set out the regulatory requirements in a concise, clear easy to read and practical format. It would mainly be for those who require medical certification (pilots and air traffic controllers) with some basic information for aviation medicine providers.

The type of information we would expect to include in a MOS would be the technical and operational detail governing the application of the regulations for:

- AMP training courses
- Appointment of Aviation Medical Practitioners (AMPs) (see note below)
- AMP currency and performance management
- Classes of medical certificates
- Medical standards for certificate classes
- Supporting processes to issue, renew, restrict, suspend, and cancel medical certificates
- Supporting processes for assurance of quality and safety in aeromedical certification
- Any other processes to support Avmed in providing safe and effective medical certification and aeromedical safety systems.

Note: Definition of AMPs - Aviation Medical Practitioner, being any medical practitioner involved in decision-making for aviation medical certification including DAMEs, treating doctors and GPs

Fact bank: Technical working group (TWG) considerations

- The other matters discussed at the TWG revolved around what could potentially be included in a MOS e.g. standards for testing vision or conducting a stress echocardiogram etc and what is outside MOS and can be more regularly updated to be current e.g. DAME Medical Manual.
- The TWG also discussed some of the other work and engagement conducted by CASA Aviation Medicine, such as holding clinical case conferences to strengthen engagement and transparency in medical decision-making. Avmed will also be conducting regional engagement and have regular slots at FlySafe events around the country.
- The TWG discussed the benefits in having the Principal Medical Officer (PMO) conducting regular engagement with aviation associations, organisations, and pilot groups.

Question 9 - Are there any other things we should consider making sure Part 67 is up to date and fit for purpose?

Response themes

57% of respondents provided considerations/comment, 30% of respondents said there were no additional considerations or no opinion/comment, and the remainder did not provide a response to this question.

Common themes across the feedback included:

Evidence and standards: Refer to the experience and approach of other jurisdictions, including consultation and feedback. Need for risk-informed and evidence-based approach to medical standards, with guidance and manuals that are in line with current best medical practice

Access and process: Consideration of complexity, time and cost around the examination and certification processes. Need for clarity on decision authority including role of CASA, DAME, GP and treating specialist

CASA AMED should take more notice of specialist reports and learn to trust the medical profession at large.

Most of it is outdated...medicine has a come a long way since those rules were made. The rules need to be updated to a modern era. Like a lot of aircraft that are dinosaur technology the aviation rules need to come into today's conditions and expectations

No. CASA's ongoing initiative to deregulate what has become an overregulated General Aviation Industry has wide support. If CASA's model is to follow the US FAA regulations, then the sooner we remove the legacy DCA/DOT/British and EAA regulations that are overlaid on the US FAA regulations to create a hybrid and overregulated Australian model the better. This applies for all Parts to the Act not just Part 67.

Theme 7 - Final feedback

Topic 7 - Consider any other relevant matters

Overview

Our review of the aviation medical rules aims to simplify and modernise our overall approach to medical certification.

Response themes

Question 10 - In addition to the information you have already provided, do you have any final suggestions to help shape our review of aviation medical policy?

77% of respondents provided final suggestions. Common themes included:

Evidence and standards: Reference should be made to other jurisdictions' certification systems. Importance of ensuring risk and evidence are considered in decision-making, which supports the matching of medical standards with the nature and risk of the operations.

> *Make it simpler and follow other countries guides. Self-testing or basic medical car license is my view. The current system is killing the GA market not to mention the over regulation taking up people's valuable time that can be used elsewhere*
>
> *Medicals are our Achilles heel as pilots…the parameters are set way too high for the average person, we don't need to be athletes to pilot an aircraft. Most of us continue the life principles of healthy body healthy mind. As for being cost effective and efficient, allow dames to issue class 1 & 2 medicals on the spot. If not, how about help us pilots out and decrease the bloody costs of all this significantly! As you know the average wage of pilots is terrible and casa wants us scrutinised 10 fold.no wonder we lose good pilots daily. Instructors specifically are paid minimum wages which do not correspond to the risks involved when training students. This needs to change.*
>
> *I'm glad CASA are looking into this. It looks as though you are looking at other countries models and engaging the community so, it can only be a good result you come up with.*

Access and process: Support for simplification and introduction of GP and self-declared certificate options, alongside clarity and simplification of the CASA decision and certification system. The importance of considering access and cost to the certificate-holder.

> *Remove Avmed from the policy review and see what you get. Let DAMES who examine real people make real decisions.*
>
> *Yes, as best we can keep CASA out of the issuing of medicals unless it is deemed necessary by a DAME medical professional.*
>
> *Costs need to be brought down. You're charging us $75 for a handling fee!?*

Future direction

The feedback from the consultation will be considered by the TWG and used to inform recommendations to the ASAP. This will occur in September and October 2022.

Subject to ASAP advise, CASA will subsequently reengage with the TWG to develop resulting draft policy positions in late 2022 and early 2023. Those draft policy positions will then undergo further public consultation expected in the first half of 2023.

* *Italic comments represent quotes where CASA has been granted permission to publish..*

Contents

Overview

Part 67 of the *Civil Aviation Safety Regulations (CASR) 1998* sets out requirements relating to medical certification, designated to aviation medical examiners and designated aviation ophthalmologists.

Regulations relevant to medical certification includes appointment of examiners medical standards, issuing and renewing certificates and suspending and cancelling certificates This regulation affects:

- designated aviation medical examiners (DAMEs)
- designated aviation ophthalmologists (DAOs)
- pilots
- air traffic controllers

In December 2016, CASA published a discussion paper exploring various policy issues. An independent report on the submissions was also submitted to CASA and released publicly.

A three-phased approach to reform CASA's approach to aviation medicine was proposed and approved in 2017. This included:

Phase 1: Implementation of immediate measures to address some of the key issues identified in the responses
Phase 2: Redesign the Class 2 medical certification system (creation of a Basic Class 2 Medical Certificate)
Phase 3: Advanced measures to ensure the entire medical certification scheme remains contemporary.

In 2018 (**Phase 2**) CASA introduced a range of changes to the aviation medical certification system by instrument: These changes included creating a new category of private pilot medical certificate (Basic Class 2) which could be assessed by any medical practitioner against the commercial driver standard, additionally allowing:

- a Class 2 medical for pilots operating commercial flights that do not carry passengers (up to a maximum take-off weight of 8618 kilograms)
- all DAMEs to have the option to issue Class 2 medical certificates on the spot, in most circumstances

This consultation addresses **Phase 3**.

Introduction

This consultation was conducted between 2 May and 12 June 2022 relating to the published Aviation Medical Policy Review (DP 2206FS), with the aim to simplify and modernise CASA's overall approach to medical certification.

CASA used its online Consultation Hub to gather data on the following 6 broad focus areas:

1. examine Part 67 to ensure it is up to date and fit for purpose
2. assess the implementation and outcomes of Basic Class 2 certification
3. determine the effectiveness of CASA delegations to DAMEs and whether these could be extended or improved, or whether DAMEs can be given direct authority under the regulations to issue medical certificates
4. consider other areas of aviation activity where medical certification could improve safety outcomes
5. establish whether the current structure of medical certification for recreational aviation is fit for purpose
6. consider any other relevant matters

Additionally, there are also 3 key potential reforms that CASA are considering:

1. self-declared medical for private pilots
2. building the principles underlying the Basic Class 2 medical certificate into Part 67 and simplifying the medical certification structure
3. empowering DAMEs to do more by expanding delegations.

Most of the data collected via this consultation was qualitative feedback, with quantitative data limited to the provision of information about demographics and self-identified aviation roles. Respondents were given a text box with no restrictions to offer their opinions and suggestions. This provided an opportunity for respondents to elaborate on ideas. A Fact Bank was provided for each policy topic to highlight significant matters that should be considered prior to responses. Responses were then analysed in terms of common themes and issues for consideration.

This consultation is relevant to all pilots (including drone flyers), medical professionals and air traffic controllers.

This is a key initiative from CASAs general aviation workplan.

Respondents

CASA received 611 responses through the Consultation hub.

68% of respondents consented to having their responses published and 32% requested their responses remain confidential but understood that de-identified aggregate data may be published. 2 respondents were CASA officers. Multiple selections were permitted (for example, a respondent might be both a DAME and a drone operator). Table 1 summarises the majority responses, and Figure 1 demonstrates the full range of responses.

The majority responses were in the following categories:	
Pilots	85%
Amateur/kit-built aircraft owners	25%
Sport aviation operators	18%
Selected one or more groups	11%
Organisations	10%
Identified as “other”	5%
DAME	2%
No category selected	3%

Table 1: Majority respondent categories

Respondents who indicated that their role was that of an organisation, where multiple stakeholder views may be represented by one submission, number 60 or 10% of responses. The nature of the organisation (such as industry representative group, flying club, private company) was not identified.

The pilot population was not further analysed in terms of type of operations (private, commercial, recreational). The data was not further analsyed in terms of which respondents were more likely to indicate a certain position on each theme; only the pooled data was reviewed for each theme and question.

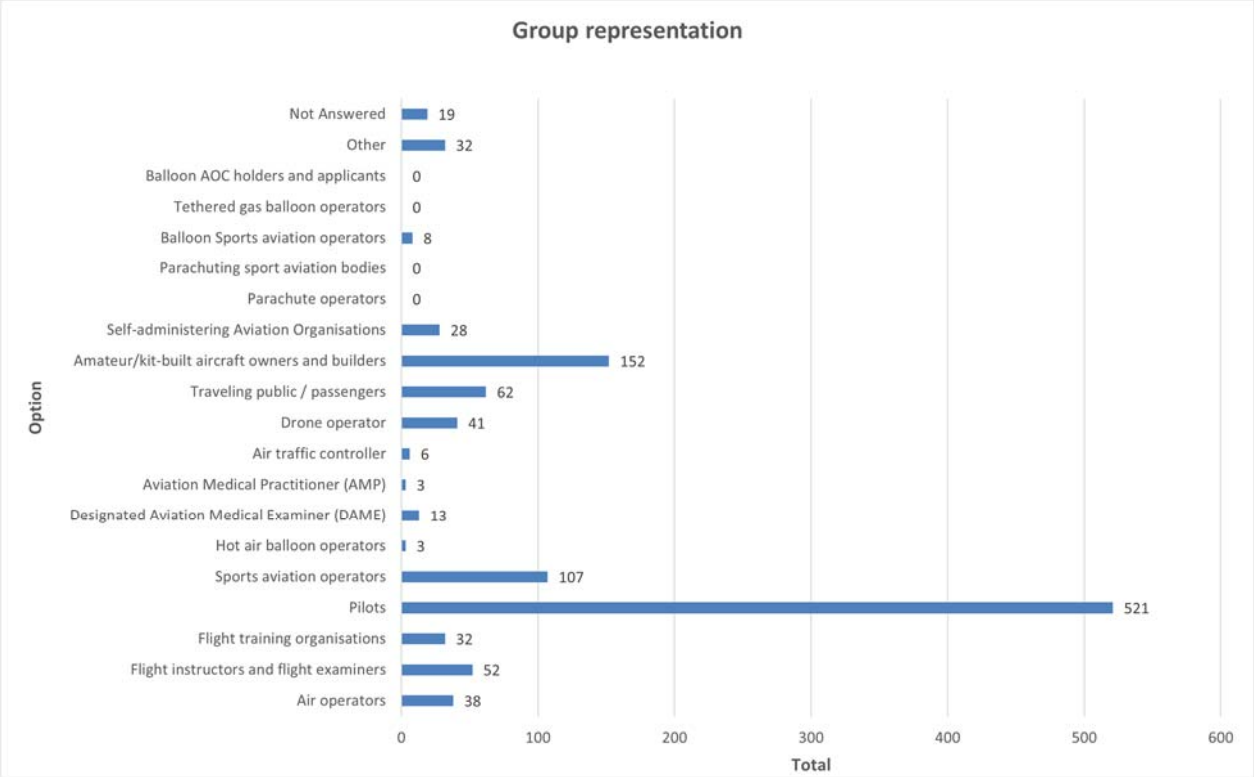

Figure 1: Group representation statistical data

Summary of Responses

Across all topics and responses, the following themes were consistently reported. Many of these themes are interconnected, for example a medical certificate issued by a doctor outside CASA (process) that requires a more detailed medical examination and doctor training (standards) will increase the cost to the applicant of seeing that doctor (access).

Access – consideration of the financial, time and effort cost to applicants of undergoing the medical examination or assessment.

Insert relevant comment

Process – desire to reduce complexity and bureaucracy, to have a simplified process that still provides an assessment that is appropriate to the level of risk, and in general to reduce the involvement of CASA in direct decision-making.

Insert relevant comment

Standards – what standard is being applied, at what level, for what kind of operations, by what medical examiner, with what level of oversight.

Insert relevant comment

Safety and risk – consideration of the need for checking compliance with the relevant standard through a process of quality assurance to ensure safety, balanced with the risk of the aviation activity.

Insert relevant comment

Evidence – experience of other jurisdictions, and the use of Australian and other data to inform decisions on individual certificate requirements and the certification system.

Insert relevant comment

Key feedback

Theme 1 - Medical certification structure

Topic 1a: Assess the implementation and outcomes of Basic Class 2 certification and of other changes to the Class 2 certification process

Overview

In 2018 we introduced a Basic Class 2 medical certificate. To enable this alternative medical certification pathway quickly and easily, we made an exemption to the rules.

Respondents were asked to consider how this review provides an opportunity to put all the rules in one place and build the Basic Class 2 principles into Part 67.

FACT BANK: Concept for simplified medical certification structure

A revision of the medical certification structure could present a logical sequence with decreasing levels of CASA involvement, offset by increasing conditions and restrictions:

- Class 1 (no change): examined by DAME, reviewed by CASA on Class 1 medical standard; possible renewal by DAME if non-complex
- Class 2 (no change to standards but streamlined processes): examined by DAME, reviewed by CASA only for cases of irreversible dementia, psychosis, or epilepsy or by DAME request, issued on Class 2 medical standard
- Class 3 (no change): examined by DAME, reviewed, and issued by CASA on Class 3 medical standard for Air Traffic Controllers
- Class 4 (replaces Basic Class 2): examined by DAME/or medical practitioner. Exploring whether this could be issued on unconditional Austroads commercial guideline (this is the same guideline as that applied to medicals for commercial truck drivers) or a new guideline developed by CASA (informed by approaches of other jurisdictions).
- Class 5 (new): self-declaration on Austroads private motor vehicle standard guideline issued by self-administering organisation or CASA

Question 1 - What do you see as issues and risks for using the Austroads standard (with additional guidance for medical practitioners to help with interpretation and decision making)?

Response themes

65% of respondents advised that they felt there were no or minimal issues and risks in adopting the Austroads standards, and 25% indicated that they felt there were issues and risk. The common themes across this feedback included:

Costs: The cost to the applicant should be considered, as it may be increased.

Process: The time taken to have the medical completed may be reduced if it becomes a simplified and more streamlined process with less involvement of CASA.

Compliance: Pilots may not declare their medical conditions, and there may be more medical events in pilots under these standards.

Standards: Suitability of the Austroads standards for the aviation environment should be considered. Additional guidance may need to be provided for medical examiners and pilots as medical practitioner may not be familiar with the standards themselves and how to apply the standards for aviation.

Risk: There may be increased safety risk relating to issues around compliance and standards, however the experience of other jurisdictions indicates that risks to aviation safety may not be significant.

Insert relevant comment(s)

Question 2 - What do you see as issues and risks if CASA was to develop a new guideline informed by the approaches of other jurisdictions?

Response themes

61% of respondents advised of no or low/minimal issues and risks, while 28% identified some issues and risks. The common themes across this feedback included:

Benefits: Using the experience and resources of larger populations and jurisdictions means CASA doesn't need to create our own version, as other jurisdictions' guidelines are already in use with no clear safety implications.

Issues: CASA may be overly conservative in developing the new guidelines. Introducing more guidelines may introduce complexity, confusion and additional cost in choosing which standard applies to whom. Implementation would require the applicants and practitioners to understand the process for it to be effective.

Insert relevant comment(s)

Topic 1b: Austroads levels

Overview

The Australian Drivers License Standards have been published in the document "Assessing Fitness to Drive" (AFTD), produced jointly by the National Transport Commission and Austroads, as an element of the Safe System approach of the National Road Safety Strategy. The private and commercial medical standards in this document are used by medical practitioners in each State to recommend to the licensing authority whether the driver is fit to drive, including whether the medical practitioner or licensing authority might apply any conditions to the license (for example, need for extra or regular tests, yearly medical examination, or restriction on the type of vehicle or type of driving).

In general terms, the drivers license standard (both private and commercial) allows for drivers to continue to drive without restriction, even when they have some diseases or medical problems. This is the "unconditional drivers license".

With certain diseases, or higher severity of some diseases, the driver (both private and commercial) may be required to see a medical practitioner to review their medical fitness to drive every year and may have some other restrictions. Some restrictions are on the recommendation of the medical practitioner completing the drivers license medical assessment, and some are at the direction of the State drivers license authority. This is the "conditional drivers license".

The diseases, severity and restrictions that allow unconditional and conditional licenses are less restrictive for private drivers, and more restrictive for commercial drivers. Each State licensing authority also has some discretion as to what medical reviews and restrictions are required for private and commercial driving in their State.

The ability to include conditions on an aviation medical using drivers license standards is a subject for discussion. Currently CASA advises applicants, as the Basic Class 2 is fundamentally the *unconditional* Austroads standard, that if they do not pass the Basic Class 2 medical, or have a pre-existing medical condition, then they should approach their DAME for a full Class 2 assessment, as DAMEs have more flexibility to consider the specific circumstances in an aviation context.

Question 3 - Considering the above which of the following options would work best?

1. A potential Class 4 certificate should bring the unconditional Commercial Austroads standard from Basic Class 2
2. There should there be flexibility to allow for a conditional issue against this standard by a GP
3. The Private Austroads standard should be considered for the Class 4 noting the unconditional application of the Commercial Austroads standard for Aviation use can be a stricter standard to meet when compared to the conditional application of a Class 2 Medical.
4. Other

Response themes

In order of popularity, respondents selected:

Option 2: Flexibility to allow for a conditional issue against this standard by a GP (32% of respondents).

Option 4: Other (29%)

Option 3: Private Austroads standards should be considered for the Class 4, noting the unconditional application of the commercial Austroads standard for Aviation use can be a stricter standard to meet (18%)

Option 1: A potential Class 4 certificate should bring the unconditional commercial Austroads standard from Basic Class 2 (12%).

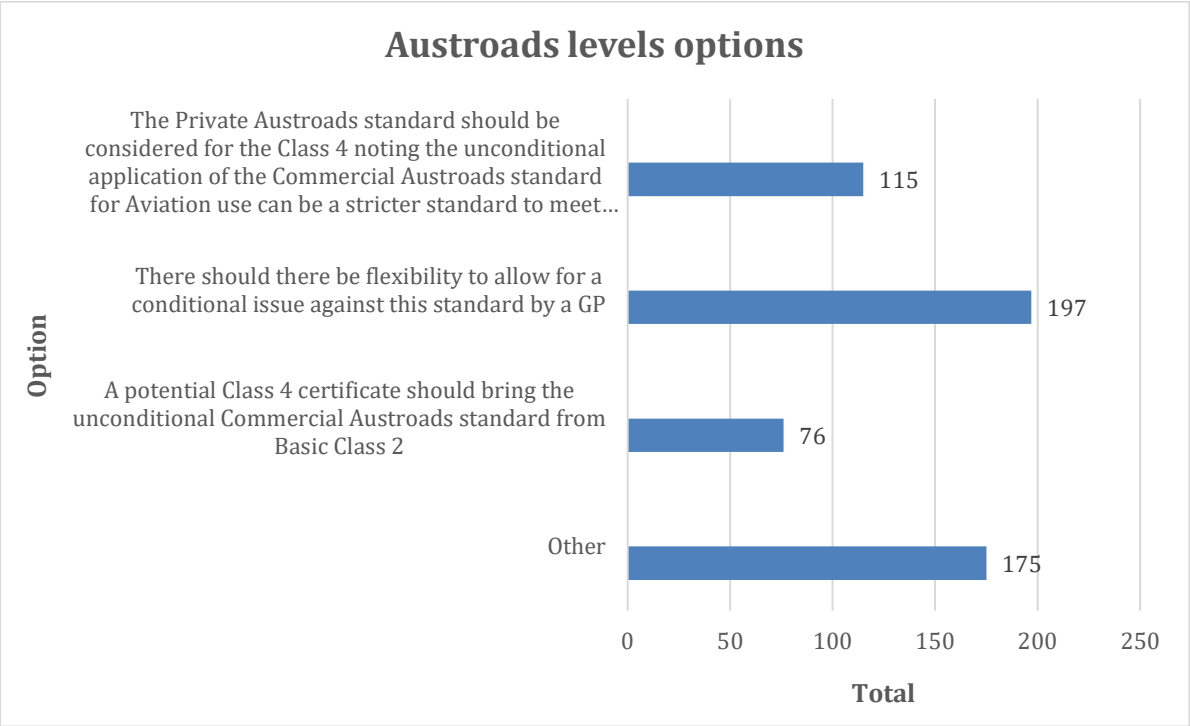

Figure 2: Austroads levels options

Commentary provided with these responses followed the following themes:

Operational restrictions: The nature of flying under the proposed certificate should be considered when choosing the medical standard (aerobatics, IFR, passengers, aircraft size and type)

Self-declared medicals: The use of the Austroads standard should be considered for a self-declared medical

Medical and examiner standards: The level of medical qualification required for certification should be matched with the level of the certificate and the standard being applied (Self, GP or DAME, ASAO, Class 1-5). The training and performance of the doctors performing the assessments will need to be considered. The suitability of the standard being used should be considered, making sure it is appropriate to aviation.

Process: The approach to drivers license-based aviation medical certificates used in other jurisdictions should be considered. The process should be simplified, with less CASA involvement.

Insert relevant comment(s)

Theme 2 - Expanding DAME delegations

Topic 2 - Determine the effectiveness of CASA delegations to Designated Aviation Medical Examiners (DAMEs) and whether these could be extended or improved.

Overview

As part of the review, we are exploring whether to extend the DAME delegation further and what training of DAMEs would be required should this happen. Early feedback on this highlights that further DAME discretion would increase their time and financial commitments. It has been suggested that a decentralised model would need to be collaborative between DAMEs and the CASA and suggests DAMEs should have the ability to opt in or out of issuing certificates.

Fact bank: Further information about the current DAME system

Part 67 enables CASA to appoint appropriately qualified persons as a DAME/ DAO (designated aviation ophthalmologist) or a Credentialed Optometrist. Currently a DAME may issue a Class 2 medical certificate to an applicant if the DAME holds a current instrument of delegation from CASA and complies with the conditions and limitations set out in the DAME Handbook. To undertake a Class 2 medical assessment the DAME must complete the Medical Assessment Report in CASA's Medical Record System (MRS) which identifies the conditions, their safety- relevance, and the certification decision.

If a DAME has any concerns about an applicant meeting the relevant medical standard, they must refer the matter to CASA for determination.

CASA considers that the DAME system has worked well, and the MRS system has improved both the effectiveness and timeliness of the issue of medical certificates.

Fact bank: Technical working group (TWG) considerations

- The TWG considered the proposal for an expansion of CASA delegations to DAMEs to further decentralise the current model.
- The TWG reviewed the proposal for DAMEs to issue Class 1 and Class 3 certificates without CASA being involved in the process, unless required when being referred complex cases. The TWG added that issuing Cl 1 and Cl 2 medical certificates should be available for DAMEs that are interested and qualified, with oversight conducted by CASA . TWG also emphasised the importance of strong investment in training, audit, and quality assurance to allow for a more decentralised model.
- The TWG discussed challenges associated with delegation, including complex case management, the potential for inconsistency in decision making by delegated DAMEs, and financial considerations such as fair compensation for DAMEs conducting full examinations. The TWG acknowledged that inconsistency of outcomes will always be apparent, however noted that consistency in approach can be safeguarded with appropriate resources e.g., up to date current medical manual and training and Medical Records System (MRS) design as an additional safety measure (rules engines that recommends when CASA should be involved) .
- The TWG discussed CAA NZ's decentralised model. It was suggested that a decentralised model would need to be collaborative between DAMEs and the CASA, particularly for complex case management. The TWG also discussed providing DAMEs with the flexibility to opt in or out of being delegated to make assessments to issue certificates. In general, the approach taken should be less CASA involvement in routine decision making and a supported DAME network who have the confidence and skills to issue routine medical certificates for a variety of low risk medical conditions and by way of accredited medical conclusion and support for CASA complex medical cases where appropriate.
- The TWG emphasised the importance to ensure there is appropriate and sufficient guidance, training, and resources for any expansion of delegations to DAMEs. It was also noted that CASA will need to have sufficient resources for DAMEs to cater for the resultant increase in oversight and training requirements.

Question 4 - What other things do you think we should explore to extend or improve DAME delegations

Response themes

28% of respondents did not make a comment, noted that they had nothing to add, or indicated that they were satisfied with the current DAME delegations.

Of the remaining 62% of respondents, common themes are listed below. Of note, 60% of comments (328 of the 551 who provided a response) indicated a desire for DAMEs to have expanded authority and responsibility for issuing medical certificates.

Expansion of DAME delegations: DAMEs should be empowered in decision-making and issuing certificates, with responses ranging from full authority to issue in all cases to DAMEs having limited authority to issue based on the medical situation.

Insert relevant comment

Variation of DAME authority: matching the authority of the DAME to issue the certificate, and the involvement of CASA, with the Class of the medical certificate.

Insert relevant comment

GPs and treating doctors: The responses ranged from allowing non-aviation treating doctors (GPs and other Specialists) to make the decision about medical certification without involving DAMEs or CASA, to allowing DAMEs to make final decisions based on GP and other Specialist advice.

Insert relevant comment

CASA's involvement: Responses included avoidance of CASA's involvement in medical certification altogether; only referring complex cases to CASA for decisions; or CASA's involvement being limited to quality assurance.

Insert relevant comment

Theme 3 - Self-declared medical for private pilots

Topic 3 - Review other areas of aviation activity where medical certification could improve safety outcomes

Overview

We announced last year that for private operations we were looking at a potential 'self-declared' medical against a driver's license standard.

One idea is for a self-declared driver's licence medical certificate for recreational pilots to be regarded as a Class 5 medical certificate under the revised certification structure outlined in Topic 2.

A self-declared medical would provide an alternative and easier pathway than the current Basic Class 2. It would encourage greater participation across the industry and is an initiative in our GA workplan to encourage growth of the sector.

Feedback from our Technical Working Group is that while this is generally a good idea, this new type of medical should not add or replicate requirements for approved self-administering aviation organisations (ASAO) under Part 149 (e.g. RAAus). It is beneficial to have uniform standards for VH aircraft and ASAOs where their purposes and operations align (e.g. RAAus and private GA flyers). However, the different medical standards across the industry could add complexity for DAMEs.

Fact bank: Technical working group (TWG) considerations

- The TWG discussed how a Class 5 self-declared medical certification would be administered and whether it would place additional (and replicated) requirements for aviation self-administering organisations (ASAOs) that operate under CASR Part 149, such as RAAus.
- The concept discussed was for CASA to set guidance for a self-declared medical certificate which is governed under CASR Part 67 and would allow certain organisations to continue to manage their own medical certification processes. In this instance, CASA's role would be to approve the processes and audit the organisation.
- Discussions also covered concepts for how ASAOs would continue to manage their assessments of self-declared medicals via their operations manuals through Part 149. The audit, compliance and oversight role of CASA for Part 149 organisations includes all elements of the ASAO's operations, which extends to the processes used by the ASAO for medical assessments and standards. CASA Avmed would work with the ASAOs to support their medical assessment processes to be safely and effectively managed under part 149, and for ASAOs would continue to be independent from the medical certification requirements for Part 67.
- The TWG considered introducing a Class 5 self-declared medical for VH-registered aircraft. The TWG discussed that the certification may be based on the Austroads private motor vehicle driving guidance. It was also noted that if the individual did not meet certain criteria, they would need a doctor to assess and issue the certificate and that CASA would need to provide guidance to support. CASA would also have an oversight and audit capability.

Question 5 - What do you consider to be the benefits of the Class 5 medical certificate concept?

Response themes

8% of respondents advised that they felt there were no benefits, and 85% of respondents identified benefits. The major theme for Question 5 responses was around improved and expanded access and availability: Class 5 would allow increased access to medical certificates for pilots based on reduced financial cost of the medical assessment; the Class 5 would be of reduced complexity and allow faster issuance of certificates. The self-declared

Class 5 would be a more flexible standard, which would mean more people could have a medical certificate.

Insert relevant comment

Question 6 - What do you consider to be issue and risks regarding the Class 5 medical certificate concept?

Response themes

54% of respondents advised no or low/minimal issues and risks, 36% of respondents identified issues and risks, with the remainder providing no response or indicating that they had no opinion.

Common themes included:

Safety: A self-declared Class 5 certificate may increase risk through non-compliance with self-declaration, where pilots with significant medical issues may not declare them. There may be increased risk due to permitting more pilots with complex medical conditions to fly.

Standards: There may be increased complexity or potential confusion over which standard applies to which pilot. A process for oversight should be considered to ensure standards are being applied correctly.

Operational considerations: A self-declared Class 5 certificate should consider the nature of the flying operations (aircraft type and registration, airspace, size, number of passengers, licence endorsements).

Access: Issues around levels of bureaucracy and administrative burden for pilots and organisations of administering a Class 5 self-declared model should be considered.

Insert relevant comment

Theme 4 - Standards for drone pilots

Topic 4 - There are no current Australian medical standards in respect of remotely piloted aircraft operations. This is an area for future policy consideration, and we would like your ideas early.

Fact bank: Technical working group (TWG) considerations

- The TWG discussed the considerations associated with remotely piloted aircraft (RPA) operations. It was raised that the weight of the RPA and the type of operation being conducted may be appropriate parameters to consider whether medical certification would be relevant – such as through a matrix.
- The TWG considered the concept of a Class 3R medical certificate for higher risk operations, and no medical certification for lower risk operations (as opposed to staggered certification based on operational risk).
- The TWG discussed the levels of redundancy and on-board capability of RPAs in the context of loss of control or possible medical episodes causing a flyaway drone. It was noted that type certified RPAs have requirements for specific on-board capabilities, and that similar capabilities are generally found (but not required) for RPAs weighing 25kg and over.
- The TWG discussed the need for further information, such as the rate of failure for RPAs and further consideration of the risk level in the context of RPAs weight (e.g. 25kg vs 150kg).

Question 7 - Do you think there are any aviation medical considerations that should be considered for pilots of remotely piloted aircraft systems (e.g. drone size, category, type, distance flown, type of operation)?

Response themes

21% of respondents said there should be no aviation medical considerations for pilots of remotely piloted aircraft systems, while 58% of respondents agreed there should be considerations for pilots of remotely piloted aircraft systems. The remainder either provided no response or indicated that this did not have a position on this question.

The responses were around two major themes, related to the medical standards, the nature of operations, and how these should be matched in considering a drone operator medical standard. Higher risk operations (commercial, controlled air space, passenger carriage, larger drones, higher altitude, outside line-of-sight) should be considered for a medical standard, while lower risk operations may have a lower medical standard or no medical standard. Respondents also indicated that CASA should consider the approach of other jurisdictions.

Insert relevant comment

Theme 5 - Flight instructors in sport and recreation

Topic 5 - Establish whether the current structure of medical certification for recreational aviation is fit for purpose

Overview

Given the importance of flight instructing as a keystone of aviation safety, it is appropriate to explore whether the general practitioner endorsement of the medical status of an instructor in the sport and recreational sector is a sufficient level of medical clearance.

Fact bank: Current medical requirements for flight instructors

Under the flight crew licensing rules (Part 61 of CASR) a flight instructor involved in flying training must hold a private, commercial or air transport pilot licence, and the relevant medical certification to enable the exercise of the privileges of their licence. An instructor in the sport and recreational aviation sector is required to hold a higher medical standard than that of recreational pilots. For example, Recreational Aviation required minimum for an instructor is a CASA Class 2 Aviation Medical Certificate or higher, or RAAus Medical Questionnaire and Examination form completed by the candidate's General Practitioner. The Gliding Federation of Australia also requires instructors to maintain their Medical Practitioner's Certificate of Fitness.

As with other forms of aviation, instructor incapacity contributing to incidents and accidents in the sport and recreational aviation sector is rare. However, given the importance of instructing as a keystone of aviation safety, it is appropriate to ask as part of a review of Part 67 whether the general practitioner endorsement of the medical status of an instructor in the sport and recreational sector is a sufficient level of medical clearance.

For example, Transport Canada's category 4 medical certificate which is primarily for recreational, ultralight and glider pilots, requires glider and ultralight Instructors to provide a medical report within five years of issue or revalidation regardless of age, and for those over 40 need an ECG at first examination and every five years thereafter. However, pilot incapacitation remains an uncommon event and while instructor incapacitation does happen (as was the case at Jandakot in August 2019 where the student pilot needed to land the aircraft after the instructor became unconscious) such an occurrence is even rarer

Fact bank: Technical working group (TWG) considerations

The TWG questioned whether a higher medical standard for instructors would actually provide extra safety outcomes.

Question 8 - Should a higher level of medical certification (e.g. a CASA Class 2 medical certificate) be required for flight instructors in the sport and recreational sector?

Response themes

Where a response was provided (from 86% of respondents), slightly more indicated a desire for a higher medical certificate for sport and recreational examiners than those who felt the medical standard should not be different to for the instructor and the student – 47% for a higher standard compared with 39% for the same standard. Common themes in these responses included:

Evidence: The decision on whether a higher medical standard is required for instructor compared to student should be based on data around medical incapacitation of instructors. The experience and approach of other jurisdictions should be considered.

Access: The impact on availability of instructors if higher medical standards are required should be considered.

Risk: The instructor medical standard should be matched to the level of risk and the nature of instruction (considering experience, flight profile, aircraft factors). This should inform what medical standard should be applied (such as self-declared, Austroads, or Part 67).

Insert relevant comment

Theme 6 - Modernising the rules

Topic 6 - Examine the Part 67 regulation to ensure it is up to date and fit for purpose

Overview

The Part 67 rules contain significant amounts of outdated material and information that, if it were being drafted now, would properly belong in a Manual of Standards (MOS) and advisory documents, rather than in the regulation itself.

Placing certain provisions in guidance material e.g. DAME Medical Manual will make it easier to change and update than having it in regulations. This will allow us to keep pace with advances in medical practice and the evolution of aviation medical regulation.

We understand that regulations can be difficult to read, so we plan to make it easier for you in the future by publishing a Plain English Guide to Part 67. It will set out the regulatory requirements in a concise, clear easy to read and practical format. It would mainly be for those who require medical certification (pilots and air traffic controllers) with some basic information for aviation medicine providers.

The type of information we would expect to include in a MOS would be the technical and operational detail governing the application of the regulations for:

- AMP training courses
- Appointment of Aviation Medical Practitioners (AMPs) (see note below)
- AMP currency and performance management
- Classes of medical certificates
- Medical standards for certificate classes
- Supporting processes to issue, renew, restrict, suspend and cancel medical certificates
- Supporting processes for assurance of quality and safety in aeromedical certification
- Any other processes to support Avmed in providing safe and effective medical certification and aeromedical safety systems.

Note: Definition of AMPs - Aviation Medical Practitioner, being any medical practitioner involved in decision-making for aviation medical certification including DAMEs, treating doctors and GPs

Fact bank: Technical working group (TWG) considerations

- The other matters discussed at the TWG revolved around what could potentially be included in a MOS e.g. standards for testing vision or conducting a stress echocardiogram etc and what is outside MOS and can be more regularly updated to be current e.g. DAME Medical Manual.
- The TWG also discussed some of the other work and engagement conducted by CASA Aviation Medicine, such as holding clinical case conferences to strengthen engagement and transparency in medical decision-making. Avmed will also be conducting regional engagement and have regular slots at FlySafe events around the country.
- The TWG discussed the benefits in having the Principal Medical Officer (PMO) conducting regular engagement with aviation associations, organisations, and pilot groups.

Question 9 - Are there any other things we should consider making sure Part 67 is up to date and fit for purpose?

Response themes

57% of respondents provided considerations/comment, 30% of respondents said there were no additional considerations or no opinion/comment, and the remainder did not provide a response to this question.

Common themes across the feedback included:

Evidence and standards: Refer to the experience and approach of other jurisdictions, including consultation and feedback. Need for risk-informed and evidence-based approach to medical standards, with guidance and manuals that are in line with current best medical practice

Access and process: Consideration of complexity, time and cost around the examination and certification processes. Need for clarity on decision authority including role of CASA, DAME, GP and treating specialist

Insert relevant comment

Theme 7 - Final feedback

Topic 7 - Consider any other relevant matters

Overview

Our review of the aviation medical rules aims to simplify and modernise our overall approach to medical certification.

Response themes

Question 10 - In addition to the information you have already provided, do you have any final suggestions to help shape our review of aviation medical policy?

77% of respondents provided final suggestions. Common themes included:

Evidence and standards: Reference should be made to other jurisdictions' certification systems. Importance of ensuring risk and evidence are considered in decision-making, which supports the matching of medical standards with the nature and risk of the operations.

Insert relevant comment

Access and process: Support for simplification and introduction of GP and self-declared certificate options, alongside clarity and simplification of the CASA decision and certification system. The importance of considering access and cost to the certificate-holder.

Insert relevant comment

Future direction

The Summary of Consultation will be considered by the TWG along with their deliberations to date, and the entirety will be used by the TWG in formulating their recommendations to the ASAP. This will occur in September and October 2022.

CASA will subsequently engage with the TWG to develop draft policy positions and potential regulatory changes in late 2022 and early 2023. Those draft policy positions will undergo further public consultation in the first half of 2023.

CASA Board Paper

Board Meeting 6-2022

Canberra

Agenda Item:	**6.2**
Board Action:	**Note**
Subject:	**Part 67 Reform and Medical Certification Structure**
Origin:	Board Action Item
Prepared by:	Aviation Medicine

Desired Outcome:

1. To provide an update on the status of Part 67 medical reform.

Executive Summary:

2. Substantial progress is being made towards delivery of reform of CASR Part 67 (Medical Certification). This reform comprises two key elements:
    a. Review of the structure of medical certification
    b. Review of the processes governing all aspects of medical certification
3. The reforms are being informed by industry consultation through a Technical Working Group (TWG) established under the Aviation Safety Advisory Panel (ASAP), broader industry consultation and international engagement (including ICAO and other regulators).
4. The ASAP Chair has recently provided advice supporting recommendations made by the Technical Working Group who considered feedback from the public consultation conducted earlier this year.
5. The recommendations included:
    a. Simplification of the medical certification structure
    b. Introduction of a 'self-declared' medical for general aviation pilots
    c. Expansion of delegations held by Designated Aviation Medical Examiners (DAME)
    d. Consideration of medical standards for Remotely Piloted Aircraft Systems
    e. Modernisation of Part 67
6. The ASAP specifically recommended that the policy on self-declared medical certification for private pilots be considered for delivery ahead of the wider reforms.
7. Delivery of the reform will ultimately be in the form of the making of a new Part 67 through legislative processes. As these processes take considerable time (potentially late 2024), interim delivery of specific outcomes is being scoped for potential implementation ahead of the regulatory change.
8. In addition to a self-declared medical, other specific outcomes being planned for potential early delivery include a system of clinical governance and professional development for medical practitioners. This would support a pathway for aeromedical decision-making that moves the role of CASA Avmed to one of governance and quality assurance.

Background:

9. The **structural review** relates to the classes of medical certificate that are issued under Part 67, including the medical standards that are required for each class, and the nature of operations permitted for each class.

10. The TWG recommendation for the delivery of a new self-declared medical certificate is now being developed in detail. Policy options are being prepared for consideration by our Aviation Safety Committee.
11. Options will include the established 'self-declared' medical scheme implemented by Recreational Aviation Australia which is limited to lightweight aircraft, a single passenger and a number of other operational constraints. Other options will consider a more flexible certifications with a greater level of medical assurance but less operational restriction.
12. The self-declared medical envisaged by the TWG had the following attributes:
    a. A medical standard that is based on the unrestricted private motor vehicle driver standard, augmented with some important aviation-specific additions which recognise the unique stressors of the flight environment while providing flexibility for the applicant and their collaborating medical practitioners.
    b. The opportunity for pilots to self-declare their medical status against this standard.
    c. The option for a further review where necessary by a suitably qualified medical practitioner, rather than requiring the non-eligible applicant to step up to a Class 2 medical.
    d. The medical standard and operational limitations under this new medical process to be risk assessed such that they support the majority of recreational flying activities for private pilots.
13. The **process review** includes governance, compliance and regulatory elements. Many of these governance processes are not dependent on legislative change, as they are provided for under flexibility provisions of Part 67 (as well as ICAO) and provisions for incorporation by reference in the DAME Handbook. These include:
    a. Credentialling, currency, professional development and performance management of various categories of aviation medical examiners
    b. Automated, DAME and Avmed assessor issuance for a wider range of low and moderate risk medical certificates
    c. Introduction of independent and collaborative review opportunities within and external to CASA for disputed decisions.
14. The review of processes will improve the effectiveness of Part 67 by providing clear directions for compliance, both in the Regulations and in a new Manual of Medical Standards. The removal of ambiguity and provision of clarity will support CASA, individual certificate-holders, aeromedical decision-makers and aviation industry with medical certification that is an enabler, rather than a barrier, to a thriving, safe aviation industry.
15. The next steps in the reform program is consideration of options by the Aviation Safety Committee to inform the development of further detailed policies in the first quarter of 2023.
16. Consultation steps are expected to include re-convening of the Technical Working Group to assist with detail followed by broader consultation in the first half of 2023 on specific detail.

Recommendation:

It is recommended the Board **note** the status on Part 67 medical reform.

Prepared by: Dr Kate Manderson, Principal Medical Officer

Approved by: Andreas Marcelja, EM Stakeholder Engagement Division

Date: 28 November 2022

Aviation Safety Committee Paper

ASC Meeting No.51

Agenda Item:	**TBA**
Board Action:	**Decision**
Subject:	**Class 4 Aviation Medical Certificate Model**
Origin:	[ASC action item?]
Prepared by:	SED (CSC-Avmed-PMO)

Desired Outcome:

1. ASC endorse the progression of work towards the proposed Class 4 aviation medical certificate under Part 67 with a view to implementation by instrument in late 2023.

Executive Summary:

2. A self-declared aviation medical certificate under Part 67 of CASRs is an important step in the modernisation of recreational aviation medical certification in Australia. For safe and effective implementation in a timely manner, CASA Avmed proposes a Class 4 self-declared medical certificate using a of a fit-for-purpose standard that is augmented by a decision-making pathway for flexible application by the pilot's suitably qualified Specialist GP.

Background:

3. Multiple rounds of consultation with stakeholders and participants in the Australian private and recreational aviation community over the last two decades have identified the importance of a self-declared aviation medical certificate. Stakeholders have sought alignment with other similar regulators including FAA, CAA UK, CAA NZ and CAA Canada. While each of these regulators' models has merits, none of them have the scope and flexibility that CASA is seeking. Attachment A details the differences in the key medical certification features of private and recreational type certificates, demonstrating the benefit of the CASA proposed approach.
4. Various approaches to self-declared medicals over the last two decades have been implemented external to Part 67 in an attempt to provide an accessible, flexible and safe recreational aviation medical certificate. These include the RAMPC, Basic Class 2 exemption and fitness assessments by ASAOs. Each of these have not been able to entirely deliver the desired outcomes, partly because they have not been supported by the comprehensive governance and implementation system that is provided with Part 67 medical certificates. As part of the reform of Part 67, a new "Class 4" self-declared aviation medical certificate is proposed to be formalised within the regulations, which will provide these extra layers of safety needed to support accessibilty and flexibility.
5. The Aviation Medicine TWG has considered options based on broad industry consultation and expert advice. Their recommendation is of a self-declared Class 4 within a strong framework of safety and quality assurance. The framework proposed by CASA Avmed to deliver this includes:
    a. development of a fit-for-purpose recreational aviation medical standard aligned with the private motor vehicle standards,
    b. simple and clear advice for users of this standard for self-declaration,
    c. pathways for escalation of decision-making to Specialist General Practitioners (SGPs) or to CASA for certification,
    d. focused training for SGPs with clear directions for application of the flexible recreational aviation medical standard, and

e. assurance of the safe and effective use of the Class 4 certification process through CASA audit and oversight.

6. This approach allows Australia's version of the recreational aviation medical certificate to be more flexible and therefore more widely accessible by the general aviation community than those available in the jurisdictions listed above. Uniquely, CASA's approach will mean that the pilot's assessing SGP will be able to work with CASA and independent aerospace medicine specialists to apply a more flexible standard and make this certificate accessible even to pilots with medical conditions that would be excluded internationally. The proposed pathway for the Class 4 medical certificate is outlined in Attachment B.
7. Operational considerations are critical to the safe implementation of the Class 4. Appropriate but not excessive operational restrictions will balance the increased acceptance of medical risk, to achieve an optimal outcome that permits the majority of recreational pilots to undertake the majority of recreational activities. The scope of operations has been determined through a series of focused risk-assessment workshops within CASA, referencing existing licensing and certification restrictions and those of other jurisdictions, and set within the CASA Board's regulatory risk appetite and Australia's aviation safety system obligations.
8. Second-order benefits of the introduction of this Class 4 certificate include the potential transfer of significant numbers of private pilots from Class 2 across to Class 4. This may result in an improved capacity for CASA and authorised DAMEs to issue Class 1, 2 and 3 certificates. Further secondary benefits include readiness in advance for a likely move by ICAO towards a recreational aviation medical certificate, and readiness for delegation of more complex cases to non-CASA aerospace medicine specialists.
9. Introduction of the Class 4 medical certificate in this proposed form has the broad support of all major stakeholders and participants and will deliver an important outcome for the recreational aviation community. Delaying introduction until the making of the new Part 67, likely to be in 2025, will not provide any additional benefit from a safety or legislative perspective, but will erode confidence and goodwill within the industry. It is therefore proposed that the Class 4 medical certificate is implemented by instrument in 2023, after development of the above systems and processes, and subsequently incorporated in the new Part 67.

Recommendation:

It is recommended the ASC **approve** the development of the proposed Class 4 recreational medical certificate and supporting governance systems and policies, for implementation by instrument in 2023.

Proposed Resolution:

The ASC approved the development of the proposed Class 4 recreational aviation medical certificate and supporting governance systems and policies, for implementation by instrument in 2023.

Prepared by: Dr Kate Manderson, Principal Medical Officer

Approved by: Andreas Marcelja, EM SED

Date: Day/Month/Year

Attachments:

A Class 4 Comparison Tables

B Class 4 Pathways to Certification

Part 67 project schedule - v0.6 as at 10 Nov 2022

ID		% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
1		**11%**		**PART 67 AMENDMENT - AVIATION MEDICAL POLICY REVIEW**	**2010 days?**	**Fri 6/10/17**	**Thu 19/06/25**			**Late**
2	✓	**100%**		**PROPOSAL INITIATION PHASE**	**1 day**	**Fri 6/10/17**	**Fri 6/10/17**			**Complete**
3	✓	100%		Shane Carmody, A/CEO and DAS approved the commencement of FS 16/08 - Medical Certification Standards Project	1 day	Fri 6/10/17	Fri 6/10/17			Complete
4		**20%**		**POLICY DEVELOPMENT PHASE (activities conducted between Oct 2017 and Apr 2022 are not included in this project schedule)**	**507 days?**	**Mon 2/05/22**	**Tue 9/04/24**			**Late**
5		**48%**		**Industry feedback on Discussion Paper (DP) 2206FS**	**165 days**	**Mon 2/05/22**	**Fri 16/12/22**			**Late**
6	✓	100%		Aviation Medical Policy Review - Public Consultation	31 days	Mon 2/05/22	Mon 13/06/22			Complete
7	✓	100%		Public consultation responses analysed	45 days	Mon 2/05/22	Fri 1/07/22	6SS	Mark Lilley,Denise Morman	Complete
8	✓	100%		AvMed team review and update SOC to include CASA's responses	15 days	Mon 4/07/22	Fri 22/07/22	7	Nathan Sullivan,Kate Manderson,Tony Hochberg	Complete
9	✓	100%		Draft SOC reviewed by RPAS Branch	2 days	Mon 25/07/22	Tue 26/07/22	8	Alison Hayward	Complete
10	✓	100%		Draft SOC reviewed by Sport & Recreational Aviation Branch	4 days	Wed 27/07/22	Mon 1/08/22	9	Tony Stanton,Steve Fickling	Complete
11	✓	100%		Draft SOC reviewed by LIRA	1 day	Tue 2/08/22	Tue 2/08/22	10	Adam Anastasi	Complete
12	✓	100%		Draft SOC reviewed by Safety Promotion	7 days	Wed 3/08/22	Thu 11/08/22	11	Mel Hamilton,Fran Hannan	Complete
13	✓	100%		AvMed team update SOC following feedback from Safety Promotion	3 days	Fri 12/08/22	Tue 16/08/22	12	Nathan Sullivan,Kate Manderson,Tony Hochberg	Complete
14	✓	100%		SOC approved by CSC Branch Manager	2 days	Wed 17/08/22	Thu 18/08/22	13	John Grima	Complete
15	✓	100%		SOC circulated to Part 67 TWG members (together with agenda, de-identified survey responses)	1 day	Thu 18/08/22	Thu 18/08/22	14FF	Mwala Putebo	Complete
16	✓	100%		SOC circulated to ASAP members	1 day	Fri 19/08/22	Fri 19/08/22	15	Mwala Putebo	Complete
17	✓	100%		TWG members review CASA's documents	5 days	Thu 18/08/22	Wed 24/08/22	15SS	Part 67 TWG members	Complete
18	✓	100%		Part 67 TWG meeting	1 day	Thu 25/08/22	Thu 25/08/22	17	Part 67 TWG members	Complete
19	✓	100%		Draft TWG report prepared by Secretariat and circulated to TWG members for feedback	1 day	Wed 31/08/22	Wed 31/08/22		Mwala Putebo	Complete
20	✓	100%		TWG provide feedback and Secretariat updates draft TWG report	7 days	Thu 1/09/22	Fri 9/09/22	19	Part 67 TWG members,Mwala Putebo	Complete
21	✓	100%		CASA PMO to review TWG report and provide final comments	3 days	Mon 12/09/22	Wed 14/09/22	20	Kate Manderson	Complete
22	✓	100%		TWG report circulated to ASAP for feedback/approval	7 days	Thu 15/09/22	Fri 23/09/22	21	Mwala Putebo	Complete
23	✓	100%		TWG report published on CASA website	1 day	Mon 26/09/22	Mon 26/09/22	22	Web team	Complete
24	✓	100%		SOC endorsed by CSC Branch Manager to proceed to QCP process	1 day	Wed 31/08/22	Wed 31/08/22		John Grima	Complete
25	✓	100%		QCP conducts editorial review and SOC is reviewed/approved via the approval workflow process	14 days	Thu 1/09/22	Tue 20/09/22	24	Carlie Brewer,Maryanne Ashton-Sporne	Complete
26	✓	100%		SED provides the DAS with the comms pack and SOC	1 day	Wed 21/09/22	Wed 21/09/22	25	Amanda Palmer	Complete
27	✓	100%		Public Holiday - Mourning of Queen Elizabeth II	1 day	Thu 22/09/22	Thu 22/09/22	26		Complete
28	✓	100%		SED circulates the SOC to the Department and TWG for info	1 day	Fri 23/09/22	Fri 23/09/22	26FF+2 d	Amanda Palmer	Complete
29	✓	100%		SOC and responses published to Consultation Hub and comms released	1 day	Mon 26/09/22	Mon 26/09/22	28	Web team	Complete
30	✓	100%		Aviation Medical Policy Review SOC published	0 days	Mon 26/09/22	Mon 26/09/22	29FF		Complete
31	✓	100%		Part 67 TWG Report published	0 days	Mon 26/09/22	Mon 26/09/22	23FF		Complete
32	✓	100%		ASAP Chair formulates advice and provides to the DAS for consideration	30 days	Mon 26/09/22	Fri 4/11/22	22	Pat Murray	Complete

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
33	5%		DAS to consider ASAP advice (including consultation with the ASC if required)	30 days	Mon 7/11/22	Fri 16/12/22	32	Pip Spence	Late
34	0%		Board Paper to be developed and presented at the 7 December 2022 Board Meeting	23 days	Mon 7/11/22	Wed 7/12/22	33SS	Nathan Sullivan,John Grima,Paul Hibberd,Denise Morman,Andreas Marcelja	Late
35	0%		Options Board to be developed and presented at the 12 December 2022 ASC meeting	26 days	Mon 7/11/22	Mon 12/12/22	33SS	Nathan Sullivan,John Grima,Andreas Marcelja	Late
36	0%		DAS to provide a written response to address the matters raised in the advice letter from the ASAP including what action CASA will be taking	3 days	Tue 13/12/22	Thu 15/12/22	35	Pip Spence	Future Task
37	0%		DAS decision communicated to AvMed to inform Policy Statement	1 day	Fri 16/12/22	Fri 16/12/22	36	Amanda Palmer	Future Task
38	0%		Public Consultation on Discussion Paper complete	0 days	Fri 16/12/22	Fri 16/12/22	37		Future Task
39	**0%**		**Policy Position Document (PPD) aka Policy Statement - Internal and TWG Consultation Only**	**219 days**	**Mon 26/09/22**	**Thu 27/07/23**			**Late**
40	0%		Secure resource to develop Policy Statement (AvMed personnel to be SMEs)	50 days	Mon 26/09/22	Fri 2/12/22	22	Paul Hibberd,Denise Morman,John Grima	Late
41	0%		Develop Policy Statement (for Part 67 Amendment including bringing forward the Class 4 Medical Certificate, Part 67 MOS and Part 67 PEG). Consider basing on "Policy Statement - Training and Testing for Multi-Engine Helicopters"	60 days	Mon 5/12/22	Fri 24/02/23	40	Policy Officer	Future Task
42	0%		Consult Policy Statement, draft PEG and DIs for Class 4 instrument with internal stakeholders and rework until content settled	10 days	Mon 27/02/23	Fri 10/03/23	41	Policy Officer	Future Task
43	0%		Policy Statement and draft PEG endorsed by internal stakeholders (LIRA, SED, FSB) and cleared by the SRO (refer row 58 re SFR for the Class 4 instrument)	10 days	Mon 13/03/23	Fri 24/03/23	42	Adam Anastasi,John Grima,Roger Crosthwaite,Andreas Marcelja	Future Task
44	0%		Prepare for TWG review/meeting (including SRO endorsement) and distribute documentation (replicated at row 62)	3 days	Fri 5/05/23	Tue 9/05/23	64SS	Mwala Putebo	Future Task
45	0%		TWG reviews CASA's documents (e.g. Policy Statement, draft PEG, draft Instrument for Class 4 Medical Certificate)	10 days	Wed 10/05/23	Tue 23/05/23	44	Part 67 TWG members	Future Task
46	0%		Virtual TWG meeting	1 day	Wed 24/05/23	Wed 24/05/23	45	Part 67 TWG members	Future Task
47	0%		Draft TWG report prepared by Secretariat and circulated to TWG members for feedback	1 day	Thu 25/05/23	Thu 25/05/23	46	Mwala Putebo	Future Task
48	0%		TWG provide feedback and Secretariat updates draft TWG report	5 days	Fri 26/05/23	Thu 1/06/23	47	Part 67 TWG members,Mwala Putebo	Future Task
49	0%		TWG report circulated to ASAP for feedback/approval	7 days	Fri 2/06/23	Mon 12/06/23	48	Mwala Putebo	Future Task
50	0%		TWG report published on CASA website	1 day	Tue 13/06/23	Tue 13/06/23	49	Web team	Future Task
51	0%		ASAP Chair formulates advice and provides to the DAS for consideration	10 days	Tue 13/06/23	Mon 26/06/23	49	Pat Murray	Future Task
52	0%		DAS to consider ASAP advice (including consultation with the ASC if required)	20 days	Tue 27/06/23	Mon 24/07/23	51	Pip Spence	Future Task
53	0%		DAS to provide a written response to address the matters raised in the advice letter from the ASAP including what action CASA will be taking	1 day	Tue 25/07/23	Tue 25/07/23	52	Pip Spence	Future Task
54	0%		Policy Statement settled and circulated to internal stakeholders (LIRA, SED, FSB) for endorsement and to the SRO for approval	40 days	Fri 2/06/23	Thu 27/07/23	49SS	Policy Officer	Future Task

ID		% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
55		0%		Policy Position Document complete - internal version only	0 days	Thu 27/07/23	Thu 27/07/23	54		Future Task
56		**0%**		**SUB-PROJECT - IMPLEMENTING CLASS 4 MEDICAL CERTIFICATE AHEAD OF OVERALL REGULATORY CHANGE**	**344 days?**	**Wed 15/06/22**	**Mon 9/10/23**			**Late**
57		**0%**		**Instrument for Class 4 Medical Certificate**	**221 days**	**Mon 5/12/22**	**Mon 9/10/23**			**Future Task**
58		0%		Prepare DIs for Instrument (concurrent with developing the Policy Statement)	60 days	Mon 5/12/22	Fri 24/02/23	41SS	Policy Officer	Future Task
59		0%		Consult Policy Statement, draft PEG and DIs for Class 4 instrument with internal stakeholders and rework until content settled	10 days	Mon 27/02/23	Fri 10/03/23	58	Policy Officer	Future Task
60		0%		SFR for the Instrument developed and cleared by CSC Branch Manager	5 days	Mon 13/03/23	Fri 17/03/23	59	Policy Officer,Nathan Sullivan,John Grima	Future Task
61		0%		SFR approved by A/EM SED	3 days	Mon 20/03/23	Wed 22/03/23	60	Andreas Marcelja	Future Task
62		0%		Approved SFR submitted to LIRA	1 day	Thu 23/03/23	Thu 23/03/23	61	John Grima	Future Task
63		0%		Policy Officer, AvMed SMEs and LIRA rework DIs until content is settled	30 days	Fri 24/03/23	Thu 4/05/23	62	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi	Future Task
64		0%		Prepare for TWG review/meeting (including SRO endorsement) and distribute documentation (replicated at row 42)	3 days	Fri 5/05/23	Tue 9/05/23	63	Mwala Putebo	Future Task
65		0%		TWG reviews CASA's documents (e.g. Policy Statement, draft PEG, draft Instrument for Class 4 Medical Certificate)	10 days	Wed 10/05/23	Tue 23/05/23	64	Part 67 TWG members	Future Task
66		0%		Virtual TWG meeting	1 day	Wed 24/05/23	Wed 24/05/23	65	Part 67 TWG members	Future Task
67		0%		Rework Instrument based on TWG feedback until settled and cleared for public consultation	30 days	Thu 25/05/23	Wed 5/07/23	66	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi,John Grima	Future Task
68		0%		Summary of Proposed Change (SPC) document developed and cleared for public consultation	12 days	Thu 6/07/23	Fri 21/07/23	67	John Grima,Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg	Future Task
69		0%		Draft questions for survey system (in conjunction with Elizabeth and the Policy Officer converting the internal Policy Statement into the external Policy Proposal Document)	12 days	Thu 6/07/23	Fri 21/07/23	68FF	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer,Elizabeth Goosen	Future Task
70		0%		Develop associated email notification comms and seek approval	5 days	Mon 17/07/23	Fri 21/07/23	68FF	Mel Hamilton	Future Task
71		0%		Set up Consultation Hub survey system	12 days	Thu 6/07/23	Fri 21/07/23	68FF	Elizabeth Goosen	Future Task
72		0%		Public Consultation	20 days	Mon 24/07/23	Fri 18/08/23	71		Future Task
73		0%		Analysis of consultation feedback and settled instrument content	20 days	Mon 31/07/23	Fri 25/08/23	72SS+5 d		Future Task
74		0%		Summary of Consultation (SOC) developed, approved and published	30 days	Mon 7/08/23	Fri 15/09/23	73SS+5 d		Future Task
75		0%		Develop explanatory statement and Statement of Compatibility with Human Rights (SCHR)	5 days	Mon 7/08/23	Fri 11/08/23	74SS	Policy Officer,Adam Anastasi	Future Task
76		0%		Finalise instrument package and complete editorial reviews	5 days	Mon 18/09/23	Fri 22/09/23	74	Adam Anastasi	Future Task

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
77	0%		Instrument package cleared by CSC Branch and A/EM SED and submitted to LIRA	2 days	Mon 25/09/23	Tue 26/09/23	76	John Grima,Andreas Marcelja,Adam Anastasi	Future Task
78	0%		Instrument package and DAS letter cleared by LIRA and submitted to the DAS for making	4 days	Wed 27/09/23	Mon 2/10/23	77	Adam Anastasi,Pip Spence	Future Task
79	0%		Instrument Made	0 days	Mon 2/10/23	Mon 2/10/23	78		Future Task
80	0%		Register on FRLI (within 4 days)	4 days	Tue 3/10/23	Fri 6/10/23	79	Nadia Spesyvy	Future Task
81	0%		Notify internal stakeholders	1 day	Mon 9/10/23	Mon 9/10/23	80	Mel Hamilton	Future Task
82	0%		Update project webpage	1 day	Mon 9/10/23	Mon 9/10/23	80	Carlie Brewer	Future Task
83	0%		Update subscriber notifications	1 day	Mon 9/10/23	Mon 9/10/23	80	Mel Hamilton	Future Task
84	0%		Instrument for Class 4 Medical Certificate complete (excluding implementation/transition)	0 days	Mon 9/10/23	Mon 9/10/23	83		Future Task
85	**0%**		**Internal Comms**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
89	**0%**		**External Comms**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
93	**0%**		**Internal Training**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
97	**0%**		**External Training (including AviationWorx)**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
102	**0%**		**Guidance Material - to be updated / new?**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
106	**0%**		**Temporary Management Instruction (TMI)?**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
110	**0%**		**Update Clinical Practice Guidelines?**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
113	**0%**		**Forms, Checklists**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
117	**0%**		**Processes, Procedures, Work Instructions, Manuals**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
121	**0%**		**System Changes? E.g. myCASA portal, MRS**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
125	**0%**		**Transition to Class 4 from Basic Class 2**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
129	**0%**		**Do we need to amend any other Instruments?**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**
132	**8%**		**Part 67 Plain English Guide (PEG)**	**350 days**	**Mon 2/05/22**	**Fri 1/09/23**			**Late**
133	9%		First draft of PEG developed (concurrent with developing the Policy Statement and drafting instructions for Class 4 Medical Certficate instrument)	215 days	Mon 2/05/22	Fri 24/02/23		Ceri Bartlett,Ron Bartsch	Late
134	0%		Consult with internal stakeholders (together with the Policy Statement and drafting instructions for Class 4 Medical Certificate instrument)	10 days	Mon 27/02/23	Fri 10/03/23	133	Ceri Bartlett	Future Task
135	0%		Second draft circulated to TWG members for review (together with Policy Statement and draft Instrument for Class 4 Medical Certificate)	10 days	Wed 10/05/23	Tue 23/05/23	45SS	Mwala Putebo	Future Task
136	0%		Third draft available for public consultation (together with the SPC document and draft Instrument for Class 4 Medical Certificate)	20 days	Mon 24/07/23	Fri 18/08/23	72SS	Ceri Bartlett	Future Task
137	0%		PEG updated as a result of public consultation	10 days	Mon 21/08/23	Fri 1/09/23	136	Ceri Bartlett,Ron Bartsch	Future Task
138	0%		Part 67 PEG complete (subject to any changes during the drafting of the regulations and MOS)	0 days	Fri 1/09/23	Fri 1/09/23	137		Future Task
139	**0%**		**Financial Impacts**	**21 days**	**Thu 23/02/23**	**Thu 23/03/23**			**Future Task**
140	0%		Complete Costing Workbook with the Finance Branch (should this meeting be earlier i.e. is this info needed for the Policy Statement?)	1 day	Thu 23/02/23	Thu 23/02/23		Nathan Sullivan,Kate Manderson,Tony Hochberg,Nicole Fahey	Future Task
141	0%		Discuss Cost Recovery Implementation Statement (CRIS) with the Finance Branch	10 days	Fri 24/02/23	Thu 9/03/23	140	Nathan Sullivan,Kate Manderson,Tony Hochberg,Nicole Fahey	Future Task
142	0%		Develop Minute/Issues Paper re costs associated with a decentralised model	10 days	Fri 10/03/23	Thu 23/03/23	141	Kate Manderson	Future Task
143	0%		Additional tasks to be added following discussions with Finance Branch	10 days	Fri 10/03/23	Thu 23/03/23	141	Denise Morman	Future Task

ID		% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
144		**65%**		**Journey Map (current and future state)**	**120 days**	**Mon 4/07/22**	**Fri 16/12/22**			**Late**
145	✓	100%		RIB to engage EDO	1 day	Mon 4/07/22	Mon 4/07/22		Denise Morman,Simon Gojkovic,Ben MacLaren	Complete
146	✓	100%		Stakeholder kick-off meeting	1 day	Tue 19/07/22	Tue 19/07/22		Denise Morman,Simon Gojkovic,Ben MacLaren,Kate Manderson,Tony Hochberg	Complete
147	✓	100%		Engagement Brief developed and approved	78 days	Wed 20/07/22	Fri 4/11/22	146	Ben MacLaren,Denise Morman	Complete
148		75%		Various stakeholder meetings conducted to identify current state and potential future state	93 days	Wed 20/07/22	Fri 25/11/22	147SS	Ben MacLaren,Denise Morman	Late
149		0%		Draft Journey Map prepared and reworked until final	103 days	Wed 20/07/22	Fri 9/12/22	147SS	Ben MacLaren	Late
150		0%		Journey map approved	5 days	Mon 12/12/22	Fri 16/12/22	149	Simon Gojkovic,John Grima	Future Task
151		0%		Journey map complete	0 days	Fri 16/12/22	Fri 16/12/22	150		Future Task
152		**0%**		**Regulatory Impact Analysis/Statement (RIA/S)**	**66 days**	**Fri 28/07/23**	**Fri 27/10/23**			**Future Task**
153		0%		Circulate approved Policy Statement to Section Manager Regulatory Impact Analysis	1 day	Fri 28/07/23	Fri 28/07/23	54	Denise Morman	Future Task
154		0%		If needed, RIB/SED relevant staff meet to discuss the Policy Statement	1 day	Fri 28/07/23	Fri 28/07/23	55	David Gilbert,Nathan Sullivan,Kate Manderson,Tony Hochberg	Future Task
155		0%		Prepare Preliminary Impact Assessment (PIA)	20 days	Mon 31/07/23	Fri 25/08/23	154	David Gilbert	Future Task
156		0%		PIA reviewed and approved	5 days	Mon 28/08/23	Fri 1/09/23	155	John Grima,Andreas Marcelja	Future Task
157		0%		Approved PIA circulated to the OBPR to determine if a RIS is required (or a RIS exemption)	20 days	Mon 4/09/23	Fri 29/09/23	156	David Gilbert	Future Task
158		0%		Additional tasks to be added following outcome of above task	20 days	Mon 2/10/23	Fri 27/10/23	157	Denise Morman	Future Task
159		**0%**		**Ministerial Submission (MinSub) Approval**	**46 days**	**Tue 6/02/24**	**Tue 9/04/24**			**Future Task**
160		0%		Prepare MinSub	20 days	Tue 6/02/24	Mon 4/03/24	207	Policy Officer	Future Task
161		0%		Provide advanced notice to the Department of upcoming MinSub	5 days	Tue 5/03/24	Mon 11/03/24	160	Paul Hibberd	Future Task
162		0%		Draft version of MinSub is reviewed by FSB, LIRA, SED, SRO and G&PS	5 days	Tue 5/03/24	Mon 11/03/24	160	Roger Crosthwaite,Adam Anastasi,John Grima,Andreas Marcelja,Leah Marshall	Future Task
163		0%		MinSub incorporated into PPD package for internal endorsement and A/EM SED approval	5 days	Tue 12/03/24	Mon 18/03/24	162	Denise Morman	Future Task
164		0%		MinSub submitted to G&PS for DAS approval	1 day	Tue 19/03/24	Tue 19/03/24	163	Denise Morman	Future Task
165		0%		MinSub approved by the DAS	3 days	Wed 20/03/24	Fri 22/03/24	164	Pip Spence	Future Task
166		0%		G&PS submits the MinSub (and supporting policy papers) to the Minister's office	1 day	Mon 25/03/24	Mon 25/03/24	165	Leah Marshall	Future Task
167		0%		MinSub and policy papers are noted by the Minister's office	10 days	Tue 26/03/24	Mon 8/04/24	166	Minister's office	Future Task
168		0%		G&PS notifies project stakeholders of noted MinSub and policy papers	1 day	Tue 9/04/24	Tue 9/04/24	167	Leah Marshall	Future Task
169		0%		MinSub Approval complete	0 days	Tue 9/04/24	Tue 9/04/24	168		Future Task
170		**11%**		**Change Impact Analysis / Benefits Realisation**	**72 days**	**Wed 2/11/22**	**Thu 9/02/23**			**On Schedule**

Part 67 project schedule - v0.6 as at 10 Nov 2022

ID		% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
171		100%		Meeting with Tegan, Simon and Ben re conducting a workshop on 24 Jan 2023	1 day	Wed 2/11/22	Wed 2/11/22		Tegan Blunden,Simon Gojkovic,Ben MacLaren	Complete
172		0%		Conduct workshop covering Change Impact Analysis and Benefits Realisation	1 day	Tue 24/01/23	Tue 24/01/23		Tegan Blunden,Simon Gojkovic,Ben MacLaren	Future Task
173		0%		Identify and document change impacts and benefits	5 days	Wed 25/01/23	Tue 31/01/23	172	Tegan Blunden,Simon Gojkovic,Ben MacLaren	Future Task
174		0%		Document circulated to workshop stakeholders for feedback	5 days	Wed 1/02/23	Tue 7/02/23	173	Denise Morman	Future Task
175		0%		Update Policy Statement re Change Impact Analysis	1 day	Wed 8/02/23	Wed 8/02/23	174	Policy Officer	Future Task
176		0%		Update Benefits Realisation section of Project Management Plan	1 day	Thu 9/02/23	Thu 9/02/23	175	Denise Morman	Future Task
177		0%		Change Impact Analysis and Benefits Realisation completed	0 days	Thu 9/02/23	Thu 9/02/23	176		Future Task
178		**0%**		**Risk Assessment Workshop Conducted / Risk Register Developed**	**16 days**	**Thu 24/11/22**	**Thu 15/12/22**			**Future Task**
179		0%		Conduct workshop	1 day	Thu 24/11/22	Thu 24/11/22		Mark Roberts	Future Task
180		0%		Develop Risk Register	5 days	Fri 25/11/22	Thu 1/12/22	179	Mark Roberts,Denise Morman	Future Task
181		0%		Risk Register circulated to workshop stakeholders for feedback	5 days	Fri 2/12/22	Thu 8/12/22	180	Denise Morman	Future Task
182		0%		Risk Register updated and approved	5 days	Fri 9/12/22	Thu 15/12/22	181	Denise Morman	Future Task
183		0%		Risk Register developed	0 days	Thu 15/12/22	Thu 15/12/22	182		Future Task
184		**0%**		**Establish Steering Committee and Terms of Reference**	**18 days**	**Mon 27/02/23**	**Wed 22/03/23**			**Future Task**
185		0%		Draft Steering Committee Terms of Reference (TOR)	5 days	Mon 27/02/23	Fri 3/03/23	42SS	Denise Morman	Future Task
186		0%		Steering Committee members review TOR and provide feedback	5 days	Mon 6/03/23	Fri 10/03/23	185	Steering Committee members	Future Task
187		0%		TOR updated and signed off	3 days	Mon 13/03/23	Wed 15/03/23	186	Denise Morman,Andreas Marcelja	Future Task
188		0%		First Steering Committee meeting scheduled (members expected to meet every 6 weeks)	5 days	Thu 16/03/23	Wed 22/03/23	187	Denise Morman	Future Task
189		0%		Steering Committee established and Terms of Reference approved	0 days	Wed 22/03/23	Wed 22/03/23	188		Future Task
190		**8%**		**Project Management Plan**	**230 days**	**Mon 4/07/22**	**Fri 19/05/23**			**Late**
191		10%		Project Management Plan (PMP) drafted and updated re policy, reg development, implementation, transition, scope, benefits, risks, resources, etc.	200 days	Mon 4/07/22	Fri 7/04/23	7	Denise Morman	Late
192		0%		PMP approved by RIB PM and circulated to Steering Committee members for review	10 days	Mon 10/04/23	Fri 21/04/23	191	Paul Hibberd,Steering Committee members	Future Task
193		0%		PMP reviewed by Steering Comittee	5 days	Mon 24/04/23	Fri 28/04/23	192	Steering Committee members	Future Task
194		0%		PMP reviewed and approved by RI BM	3 days	Mon 1/05/23	Wed 3/05/23	193	Paul Hibberd	Future Task
195		0%		PMP reviewed and approved by Section Manager AvMed	3 days	Thu 4/05/23	Mon 8/05/23	194	Nathan Sullivan	Future Task
196		0%		PMP reviewed and approved by CSC BM	3 days	Tue 9/05/23	Thu 11/05/23	195	John Grima	Future Task
197		0%		PMP reviewed and approved by SRO and A/EM SED	3 days	Fri 12/05/23	Tue 16/05/23	196	Andreas Marcelja	Future Task
198		0%		PMP reviewed and approved by EM NOS	3 days	Wed 17/05/23	Fri 19/05/23	197	Chris Monahan	Future Task
199		0%		Project Management Plan approved	0 days	Fri 19/05/23	Fri 19/05/23	198		Future Task
200		**0%**		**Gate Review - are we ready to move to the Regulatory Development Phase**	**5 days**	**Tue 10/10/23**	**Mon 16/10/23**			**Future Task**
201		0%		Prepare for Gate Review (confirm documents, impacted stakeholders, schedule meeting, availability of resources)	2 days	Tue 10/10/23	Wed 11/10/23	83	Denise Morman	Future Task

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
202	0%		Conduct Gate Review and confirm we are ready to move to the Standards Development Phase	1 day	Thu 12/10/23	Thu 12/10/23	201	Denise Morman,Paul Hibberd	Future Task
203	0%		Update Gate Review documentation and circulate	2 days	Fri 13/10/23	Mon 16/10/23	202	Denise Morman	Future Task
204	0%		Gate Review completed	0 days	Mon 16/10/23	Mon 16/10/23	203		Future Task
205	**0%**		**REGULATORY DEVELOPMENT PHASE**	**438 days**	**Tue 17/10/23**	**Thu 19/06/25**			**Future Task**
206	**0%**		**Regulations, CATS and Fees Regulations**	**438 days**	**Tue 17/10/23**	**Thu 19/06/25**			**Future Task**
207	0%		Prepare Drafting Instructions (DIs) for regulations, CATS and fees regulations	80 days	Tue 17/10/23	Mon 5/02/24	204	Policy Officer	Future Task
208	0%		Consult DIs with internal stakeholders	5 days	Tue 6/02/24	Mon 12/02/24	207	Policy Officer	Future Task
209	0%		Policy Officer, AvMed SMEs and LIRA rework DIs until content settled	10 days	Tue 13/02/24	Mon 26/02/24	208	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi	Future Task
210	0%		Settled DIs approved by SRO	3 days	Tue 27/02/24	Thu 29/02/24	209	Andreas Marcelja	Future Task
211	0%		Draft OPC Readiness Minute for EM approval	5 days	Fri 1/03/24	Thu 7/03/24	210	Policy Officer	Future Task
212	0%		OPC Readiness Minute approved by A/EM SED	2 days	Fri 8/03/24	Mon 11/03/24	211	Chris Monahan,Andreas Marcelja	Future Task
213	0%		CASA clearance to commence drafting with OPC	2 days	Tue 12/03/24	Wed 13/03/24	212	Paul Hibberd	Future Task
214	0%		Policy Officer, AvMed SMEs, LIRA and OPC refine Reg and rework content until settled	50 days	Thu 14/03/24	Wed 22/05/24	213	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi,OPC drafter	Future Task
215	0%		Prepare for TWG review/meeting (including SRO endorsement) and distribute documentation	3 days	Thu 23/05/24	Mon 27/05/24	214	Mwala Putebo	Future Task
216	0%		TWG reviews CASA's documents	10 days	Tue 28/05/24	Mon 10/06/24	215	Part 67 TWG members	Future Task
217	0%		Virtual TWG meeting	1 day	Tue 11/06/24	Tue 11/06/24	216	Part 67 TWG members	Future Task
218	0%		Draft TWG report prepared by Secretariat and circulated to TWG members for feedback	1 day	Wed 12/06/24	Wed 12/06/24	217	Mwala Putebo	Future Task
219	0%		TWG provide feedback and Secretariat updates draft TWG report	5 days	Thu 13/06/24	Wed 19/06/24	218	Part 67 TWG members,Mwala Putebo	Future Task
220	0%		CASA PMO to review TWG report and provide final comments	3 days	Thu 20/06/24	Mon 24/06/24	219	Kate Manderson	Future Task
221	0%		TWG report circulated to ASAP for feedback/approval	7 days	Thu 20/06/24	Fri 28/06/24	219	Mwala Putebo	Future Task
222	0%		TWG report published on CASA website	1 day	Mon 1/07/24	Mon 1/07/24	221	Web team	Future Task
223	0%		Exposure Draft updated with TWG and ASAP feedback - CASA and OPC rework until finalised	20 days	Thu 20/06/24	Wed 17/07/24	221SS	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi,OPC drafter	Future Task
224	0%		ASAP Chair formulates advice and provides to the DAS for consideration	5 days	Mon 1/07/24	Fri 5/07/24	221	Pat Murray	Future Task

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
225	0%		DAS to consider ASAP advice (including consultation with the ASC if required)	15 days	Mon 8/07/24	Fri 26/07/24	224	Pip Spence	Future Task
226	0%		DAS to provide a written response to address the matters raised in the advice letter from the ASAP including what action CASA will be taking	1 day	Mon 29/07/24	Mon 29/07/24	225	Pip Spence	Future Task
227	0%		DAS decision communicated to AvMed team to inform Public Consultation	1 day	Tue 30/07/24	Tue 30/07/24	226	Amanda Palmer	Future Task
228	0%		AvMed SMEs, Policy Officer and Regulatory Development Coordinator finalise format of consultation documents	12 days	Wed 31/07/24	Thu 15/08/24	227	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer,Elizabeth Goosen	Future Task
229	0%		Draft questions for survey system	12 days	Wed 31/07/24	Thu 15/08/24	228SS	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer	Future Task
230	0%		Reg comms finalised and approved	12 days	Wed 31/07/24	Thu 15/08/24	228SS	Mel Hamilton	Future Task
231	0%		Set up Consultation Hub survey system	12 days	Wed 31/07/24	Thu 15/08/24	228SS	Elizabeth Goosen	Future Task
232	0%		Exposure Draft cleared by LIRA	12 days	Wed 31/07/24	Thu 15/08/24	228SS	Adam Anastasi	Future Task
233	0%		Public Consultation	20 days	Fri 16/08/24	Thu 12/09/24	232		Future Task
234	0%		Public Consultation responses analysed and SOC drafted (consider outsourcing analysis work)	30 days	Fri 23/08/24	Thu 3/10/24	233SS+5 days		Future Task
235	0%		Consider consultation feedback and amend policy documents/prepare drafting instructions etc - CASA and OPC rework until finalised	40 days	Fri 23/08/24	Thu 17/10/24	234SS	Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi,Policy Officer,OPC drafter	Future Task
236	0%		AvMed team review and update SOC to include CASA's responses (if required)	5 days	Fri 4/10/24	Thu 10/10/24	234	Nathan Sullivan,Kate Manderson,Tony Hochberg	Future Task
237	0%		Draft SOC, amended policy documents and Exposure Draft reviewed by impacted internal business areas	10 days	Fri 11/10/24	Thu 24/10/24	236	Policy Officer	Future Task
238	0%		SOC endorsed by CSC Branch Manager to proceed to QCP process	1 day	Fri 25/10/24	Fri 25/10/24	237	John Grima	Future Task
239	0%		QCP conducts editorial review and SOC is reviewed/approved via the approval workflow process	5 days	Mon 28/10/24	Fri 1/11/24	238	Carlie Brewer,Maryanne Ashton-Sporne	Future Task
240	0%		SED provides the DAS with the comms pack and SOC	1 day	Mon 4/11/24	Mon 4/11/24	239	Amanda Palmer	Future Task
241	0%		SED circulates the SOC to the Department and TWG for info	1 day	Tue 5/11/24	Tue 5/11/24	240	Amanda Palmer	Future Task
242	0%		SOC and responses published to the Consultation Hub	0 days	Tue 5/11/24	Tue 5/11/24	241		Future Task
243	0%		Policy Officer drafts Explanatory Memorandum (EM) and LIRA reviews	10 days	Fri 13/09/24	Thu 26/09/24	233	Policy Officer	Future Task
244	0%		Letter to Minister and EM sent to the Department for initial review	1 day	Fri 27/09/24	Fri 27/09/24	243	Paul Hibberd,Leah Marshall	Future Task
245	0%		Policy Officer/LIRA and Department rework EM until content settled	10 days	Mon 30/09/24	Fri 11/10/24	244	Policy Officer,Adam Anastasi	Future Task
246	0%		LIRA drafts the Statement of Compatibility with Human Rights (SCHR)	7 days	Fri 13/09/24	Mon 23/09/24	243SS	Adam Anastasi	Future Task

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
247	0%		Policy Officer prepares Explanatory Statement (ES) for approval by LIRA, AvMed SMEs and the SRO	5 days	Mon 14/10/24	Fri 18/10/24	245	Policy Officer,Adam Anastasi,Kate Manderson,Tony Hochberg,John Grima,Nathan Sullivan	Future Task
248	0%		Policy Officer, AvMed SMEs and LIRA finalise Initial Reg Approval Package (Reg, RIS, SCHR, ES, DAS Minute, Letter to the Minister)	7 days	Fri 18/10/24	Mon 28/10/24	235	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,John Grima,Adam Anastasi,David Gilbert	Future Task
249	**0%**		**Gate Review - are we ready to 'make' the rules**	**5 days**	**Fri 25/10/24**	**Thu 31/10/24**			**Future Task**
250	0%		Prepare for Gate Review (confirm documents, impacted stakeholders, schedule meeting, availability of resources)	2 days	Fri 25/10/24	Mon 28/10/24	248FF	Denise Morman	Future Task
251	0%		Conduct Gate Review and confirm we are ready to move to the Standards Development Phase	1 day	Tue 29/10/24	Tue 29/10/24	250	Paul Hibberd,Denise Morman	Future Task
252	0%		Update Gate Review documentation and circulate	2 days	Wed 30/10/24	Thu 31/10/24	251	Denise Morman	Future Task
253	0%		Gate Review completed	0 days	Thu 31/10/24	Thu 31/10/24	252		Future Task
254	**0%**		**'Make' process**	**41 days**	**Fri 25/10/24**	**Fri 20/12/24**			**Future Task**
255	0%		CSC and LIRA approve Regulatory Approval package and sends to the DAS	3 days	Fri 25/10/24	Tue 29/10/24	250SS	John Grima,Adam Anastasi,Andreas Marcelja	Future Task
256	0%		DAS approves Regulatory Approval package	3 days	Wed 30/10/24	Fri 1/11/24	255	Pip Spence	Future Task
257	0%		RIB forwards the Minister's letter and approval package to the Department for the Minister's approval	1 day	Mon 4/11/24	Mon 4/11/24	256	Paul Hibberd,Leah Marshall	Future Task
258	0%		Department prepares ExCO minute/paper and sends to Minister for approval	15 days	Tue 5/11/24	Mon 25/11/24	257	Department POC	Future Task
259	0%		Minister's office submits regulation package, explanatory memo and ExCo minute to ExCo for rulemaking by the Governor General	12 days	Tue 26/11/24	Wed 11/12/24	258	Minister's office	Future Task
260	0%		EXCO meeting (Note: Date to be confirmed once meeting schedule is published)	1 day	Thu 12/12/24	Thu 12/12/24	259		Future Task
261	0%		Regulation Amendment Made	0 days	Thu 12/12/24	Thu 12/12/24	260		Future Task
262	0%		Register on FRLI (within 4 days)	4 days	Fri 13/12/24	Wed 18/12/24	261	Nadia Spesyvy	Future Task
263	0%		Notify internal stakeholders	1 day	Thu 19/12/24	Thu 19/12/24	262	Mel Hamilton	Future Task
264	0%		Update project webpage	1 day	Fri 20/12/24	Fri 20/12/24	263	Carlie Brewer	Future Task
265	0%		Update subscriber notifications	1 day	Fri 20/12/24	Fri 20/12/24	263	Mel Hamilton	Future Task
266	**0%**		**Disallowance Period**	**135 days**	**Fri 13/12/24**	**Thu 19/06/25**			**Future Task**
267	0%		Part 67 amendment	135 days	Fri 13/12/24	Thu 19/06/25	261SS		Future Task
268	0%		Disallowance Period ended	0 days	Thu 19/06/25	Thu 19/06/25	267		Future Task
269	**0%**		**Part 67 Manual of Standards (MOS)**	**299 days**	**Tue 31/10/23**	**Fri 20/12/24**			**Future Task**
270	0%		Develop MOS Drafting Instructions (in conjunction with the reg DIs)	70 days	Tue 31/10/23	Mon 5/02/24	207FF	Policy Officer	Future Task
271	0%		Consult DIs with Internal stakeholders	3 days	Tue 6/02/24	Thu 8/02/24	208SS	Policy Officer	Future Task

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
272	0%		Settle DIs, SFR drafted and approved by SRO for submission to LIRA	8 days	Fri 9/02/24	Tue 20/02/24	271	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,John Grima,Andreas Marcelja	Future Task
273	0%		Policy Officer, AvMed SMEs and LIRA rework DIs until content settled	15 days	Wed 21/02/24	Tue 12/03/24	272	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi	Future Task
274	0%		SRO endorsement of DIs	1 day	Wed 13/03/24	Wed 13/03/24	273	Andreas Marcelja	Future Task
275	0%		Policy Officer, AvMed SMEs and LIRA develop MOS and rework content until settled	50 days	Thu 14/03/24	Wed 22/05/24	274	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi	Future Task
276	0%		Prepare for TWG review/meeting (including SRO endorsement) and distribute documentation	3 days	Thu 23/05/24	Mon 27/05/24	275	Mwala Putebo	Future Task
277	0%		TWG reviews CASA's documents	10 days	Tue 28/05/24	Mon 10/06/24	276	Part 67 TWG members	Future Task
278	0%		Virtual TWG meeting	1 day	Tue 11/06/24	Tue 11/06/24	277	Part 67 TWG members	Future Task
279	0%		Draft TWG report prepared by Secretariat and circulated to TWG members for feedback	1 day	Wed 12/06/24	Wed 12/06/24	278	Mwala Putebo	Future Task
280	0%		TWG provide feedback and Secretariat updates draft TWG report	5 days	Thu 13/06/24	Wed 19/06/24	279	Mwala Putebo,Part 67 TWG members	Future Task
281	0%		CASA PMO to review TWG report and provide final comments	3 days	Thu 20/06/24	Mon 24/06/24	280	Kate Manderson	Future Task
282	0%		TWG report circulated to ASAP for feedback/approval	7 days	Thu 20/06/24	Fri 28/06/24	280	Mwala Putebo	Future Task
283	0%		TWG report published on CASA website	1 day	Mon 1/07/24	Mon 1/07/24	282	Web team	Future Task
284	0%		Policy Officer, AvMed SMEs and LIRA refine MOS content post TWG if required	8 days	Mon 1/07/24	Wed 10/07/24	282	Policy Officer,Nathan Sullivan,Kate Manderson,Tony Hochberg,Adam Anastasi	Future Task
285	0%		ASAP Chair formulates advice and provides to the DAS for consideration	5 days	Mon 1/07/24	Fri 5/07/24	282	Pat Murray	Future Task
286	0%		DAS to consider ASAP advice (including consultation with the ASC if required)	15 days	Mon 8/07/24	Fri 26/07/24	285	Pip Spence	Future Task
287	0%		DAS to provide a written response to address the matters raised in the advice letter from the ASAP including what action CASA will be taking	1 day	Mon 29/07/24	Mon 29/07/24	286	Pip Spence	Future Task
288	0%		DAS decision communicated to AvMed team to inform Public Consultation	1 day	Tue 30/07/24	Tue 30/07/24	287	Amanda Palmer	Future Task
289	0%		AvMed SMEs, Policy Officer and Regulatory Development Coordinator finalise format of consultation documents	12 days	Wed 31/07/24	Thu 15/08/24	288	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer,Elizabeth Goosen	Future Task

ID	% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
290	0%		Draft questions for survey system	12 days	Wed 31/07/24	Thu 15/08/24	289SS	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer	Future Task
291	0%		Reg comms finalised and approved	12 days	Wed 31/07/24	Thu 15/08/24	289SS	Mel Hamilton	Future Task
292	0%		Set up Consultation Hub survey system	12 days	Wed 31/07/24	Thu 15/08/24	289SS	Elizabeth Goosen	Future Task
293	0%		MOS cleared by LIRA	12 days	Wed 31/07/24	Thu 15/08/24	289SS	Adam Anastasi	Future Task
294	0%		Public Consultation	20 days	Fri 16/08/24	Thu 12/09/24	293		Future Task
295	0%		Public Consultation responses analysed and SOC drafted (consider outsourcing analysis work)	30 days	Fri 23/08/24	Thu 3/10/24	294SS+5 days		Future Task
296	0%		Consider consultation feedback and amend MOS - Policy Officer, AvMed SMEs and LIRA rework until finalised	40 days	Fri 23/08/24	Thu 17/10/24	295SS	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer,Adam Anastasi	Future Task
297	0%		AvMed team review and update SOC to include CASA's responses (if required)	5 days	Fri 4/10/24	Thu 10/10/24	295	Nathan Sullivan,Kate Manderson,Tony Hochberg	Future Task
298	0%		Draft SOC and MOS reviewed by impacted internal business areas	10 days	Fri 11/10/24	Thu 24/10/24	297	Policy Officer	Future Task
299	0%		SOC endorsed by CSC Branch Manager to proceed to QCP process	1 day	Fri 25/10/24	Fri 25/10/24	298	John Grima	Future Task
300	0%		QCP conducts editorial review and SOC is reviewed/approved via the approval workflow process	5 days	Mon 28/10/24	Fri 1/11/24	299	Carlie Brewer,Maryanne Ashton-Sporne	Future Task
301	0%		SED provides the DAS with the comms pack and SOC	1 day	Mon 4/11/24	Mon 4/11/24	300	Amanda Palmer	Future Task
302	0%		SED circulates the SOC to the Department and TWG for info	1 day	Tue 5/11/24	Tue 5/11/24	301	Amanda Palmer	Future Task
303	0%		SOC and responses published to the Consultation Hub	0 days	Tue 5/11/24	Tue 5/11/24	302		Future Task
304	0%		Policy Officer, AvMed SMEs and LIRA finalise MOS Package (MOS, SCHR, ES, DAS Minute)	9 days	Wed 6/11/24	Mon 18/11/24	303	Nathan Sullivan,Kate Manderson,Tony Hochberg,Policy Officer,Adam Anastasi	Future Task
305	**0%**		**Gate Review - are we ready to 'make' the MOS**	**5 days**	**Fri 25/10/24**	**Thu 31/10/24**			**Future Task**
306	0%		Prepare for Gate Review (confirm documents, impacted stakeholders, schedule meeting, availability of resources)	2 days	Fri 25/10/24	Mon 28/10/24	298	Denise Morman	Future Task
307	0%		Conduct Gate Review and confirm we are ready to move to the Standards Development Phase	1 day	Tue 29/10/24	Tue 29/10/24	306	Denise Morman,Paul Hibberd	Future Task
308	0%		Update Gate Review documentation and circulate	2 days	Wed 30/10/24	Thu 31/10/24	307	Denise Morman	Future Task
309	0%		Gate Review completed	0 days	Thu 31/10/24	Thu 31/10/24	308		Future Task
310	**0%**		**MOS Make Process**	**41 days**	**Fri 25/10/24**	**Fri 20/12/24**			**Future Task**
311	0%		CSC and LIRA approve MOS Package and sends to DAS	3 days	Fri 25/10/24	Tue 29/10/24	306SS	Policy Officer,Adam Anastasi,John Grima,Andreas Marcelja	Future Task
312	0%		DAS approves MOS Package	3 days	Wed 30/10/24	Fri 1/11/24	311	Pip Spence	Future Task
313	0%		Contingency (if needed)	28 days	Mon 4/11/24	Wed 11/12/24	312		Future Task
314	0%		MOS Made (to be aligned with Reg make date)	0 days	Thu 12/12/24	Thu 12/12/24	261		Future Task
315	0%		Register on FRLI (within 4 days)	4 days	Fri 13/12/24	Wed 18/12/24	314	Nadia Spesyvy	Future Task
316	0%		Notify internal stakeholders	1 day	Thu 19/12/24	Thu 19/12/24	315	Mel Hamilton	Future Task
317	0%		Update project webpage	1 day	Fri 20/12/24	Fri 20/12/24	316	Carlie Brewer	Future Task
318	0%		Update subscriber notifications	1 day	Fri 20/12/24	Fri 20/12/24	316	Mel Hamilton	Future Task

ID		% Work Complete	Task Mode	Task Name	Duration	Start	Finish	Predecess	Resource Names	Status
319		**0%**		**Exemption Instrument/Delegation Instrument review**	**54 days**	**Mon 25/03/24**	**Thu 6/06/24**			**Future Task**
338		**1%**		**IMPLEMENTATION PHASE (pre rule making) - Tasks and timeframes yet to be scheduled**	**210 days?**	**Wed 15/06/22**	**Tue 4/04/23**			**Late**
363		**0%**		**IMPLEMENTATION PHASE (post rule making) - Tasks and timeframes yet to be scheduled**	**1 day?**	**Wed 15/06/22**	**Wed 15/06/22**			**Late**

Australian Government
Civil Aviation Safety Authority

POLICY PROPOSAL

PP 2302FS

Policy proposal for a new aviation medical self-declaration

Date	October 2023
Project number	FS 04/01
File ref	D23/461700

Overview

Part 67 of the *Civil Aviation Safety Regulations 1998* (CASR) sets out the requirements relating to medical certification and the requirements for designated aviation medical examiners and designated aviation ophthalmologists that undertake medical assessments.

Over the past two decades, multiple stakeholders and participants in the Australian aviation community have expressed the value of a self-declared medical scheme. A key initiative of CASA's Part 67 reform workplan is delivering an accessible and simplified medical certificate model for the recreational aviation community.

Various approaches to modernising the aviation medical scheme have attempted to provide an accessible, simplified, and safe aviation medical certificate. These include the Recreational Aviation Medical Practitioner Certificate (RAMPC) and the Basic Class 2 medical certificate.

The proposed scheme, namely Class 5 medical self-declaration, is an alternative to the current Basic Class 2 and RAMPC medical certificates in terms of not requiring review by an aviation medical examiner. However, it is different as it permits greater flexibility in the presence of medical conditions and does not mandate a review by a medical practitioner. It is intended that the Class 5 medical self-declaration will replace the RAMPC once there is an opportunity to amend the relevant parts of CASR. Appendix A of this policy proposal (PP) provides a comparison table of the proposed Class 5 medical self-declaration with other recreational aviation medical certificates.

The proposed Class 5 medical self-declaration aims to ensure that safety risks are managed appropriately without requiring a medical assessment by a medical professional as part of the application process, or scrutiny of individual certificates by CASA aviation medicine specialists.

The acceptable levels of risk associated with the self-declaration certification scheme will be managed through operational limitations, medical limitations, and self-declared medical assurances.

The proposed Class 5 medical self-declaration will include:

a. A self-assessment and self-declaration process for the automatic issuance of a Class 5 medical self-declaration, completed entirely online.
b. Medical limitations that exclude pilots with certain conditions from the Class 5 medical self-declaration.
c. Operational limitations, that include but are not limited to, the size of aircraft used, and the kinds of operations performed.
d. The provision of comprehensive guidance material for applicants, certificate-holders and their healthcare practitioners, regarding aeromedical risk assessment for states of health and diseases.

Why are we consulting?

CASA is seeking your feedback to determine whether this PP for an aviation medical self-declaration scheme meets the needs of the recreational aviation community while retaining an acceptable level of aviation safety.

This consultation is relevant to all pilots, key aviation stakeholder organisations, flight training operators/flight instructors, and medical professionals. This is an opportunity to provide industry sector insights and feedback based on current needs and challenges.

Contents

1 Reference material

1.1 Acronyms

The acronyms and abbreviations used in this Policy Proposal are listed in the table below.

Acronym	Description
A-LOC	almost loss of consciousness
AME	Aviation Medical Examiner
ATSB	Australian Transport Safety Bureau
AvMed	Aviation Medicine
CASA	Civil Aviation Safety Authority
CASR	Civil Aviation Safety Regulations 1998
CTA	controlled airspace
DAME	Designated Aviation Medical Examiner
DVLA	Driver and Vehicle Licensing Agency
G-LOC	G induced loss of consciousness
G	G-force
GP	General Practitioner
ICAO	International Civil Aviation Organization
LAPL	Light Aircraft Pilot Licence
MOS	Manual of Standards
MP	Medical Practitioner
MRS	Medical Records System
OCTA	outside of controlled airspace
PMD	Pilot Medical Declaration
PP	policy proposal
PPL	Private Pilot's Licence
RAMPC	Recreational Aviation Medical Practitioners Certificate
RPL	Recreational Pilot's Licence
SAB	sport aviation body
SARP	Standards and Recommended Practices
SD	spatial disorientation
SGP	Specialist General Practitioner
TWG	Technical Working Group
UK PMD	United Kingdom Pilot Medical Declaration

1.2 Definitions

Terms that have specific meaning within this PP are defined in the table below. Where definitions from the civil aviation legislation have been reproduced for ease of reference, these are identified by 'grey shading'. Should there be a discrepancy between a definition given in this PP and the civil aviation legislation, the definition in the legislation prevails.

Term	Definition
guidelines	means the Guidelines - Medical Assessment for Aviation
healthcare practitioner	means a qualified and registered health care professional, such as a medical practitioner, medical specialist, optometrist, physiotherapist, or other healthcare professional
medical requirements	means the medical requirements outlined in the Guidelines - Medical Assessment for Aviation
private operations	an operation of an aircraft is a private operation if the operation is not one of the following: a. an operation that is required to be conducted under the authority of an AOC under Part 119, 129 or 131 or regulation 206 of CAR b. an operation that is required to be conducted under the authority of an aerial work certificate under Part 138 c. Part 141 flight training (within the meaning of Part 141) d. a Part 142 activity (within the meaning of Part 142) e. an adventure flight for a limited category aircraft f. a specialised balloon operation that is conducted for hire or reward g. an operation authorised by a New Zealand AOC with ANZA privileges that is in force for Australia h. an operation under a permission under subsection 25(2) or (3) (non-scheduled flights by foreign registered aircraft) or section 27A (permission for operation of foreign registered aircraft without AOC) of the Act.

1.3 References

Legislation

Legislation is available on the Federal Register of Legislation website https://www.legislation.gov.au/

Document	Title
Part 61 of CASR	Flight crew licensing
Part 67 of CASR	Medical
CASA EX69/21	CASA EX 69/21 - Medical Certification (Private Pilot Licence Holders with Basic Class 2 Medical Certificate) Exemption 2021

Advisory material

CASA's advisory materials are available at https://www.casa.gov.au/publications-and-resources/guidance-materials

Document	Title
	Draft Guidelines - Medical Assessment for Aviation

Other references

Document	Title
Austroads	Assessing Fitness to Drive for commercial and private vehicle drivers (2022 Edition)
ICAO Annex 1	Personnel Licencing (Twelfth Edition, July 2018)
ICAO Annex 19	Safety Management (Second Edition, July 2016)
ICAO Doc 7300	Convention on International Civil Aviation (Ninth Edition, 2006)
ICAO Doc 8984	Manual of Civil Aviation Medicine

1.4 Forms

CASA's forms are available at http://www.casa.gov.au/forms

Form number	Title
Form 166	Recreational Aviation Medical Practitioner's Certificate (RAMPC)
Form 1473	Basic Class 2 medical certificate (available via MRS)

2 Introduction

2.1 Background

Pilots and air traffic controllers must hold a current medical certificate to exercise the privileges of their pilot licence. For pilots, different classes of medical certificates are required to conduct different kinds of operations or hold different kinds of pilot licences.

Part 61 of the *Civil Aviation Safety Regulations 1998* (CASR) and its related Manual of Standards (MOS) set out the requirements and standards for the issue of flight crew licences, ratings, and other authorisations. At a minimum, a Part 61 Recreational Pilots Licence (RPL) is required to be able to fly for recreational purposes.

Medical standards underpin the assurance of acceptable levels of aviation safety by minimising the risk of pilots experiencing medical-induced issues that may lead to in-flight impairment or incapacitation. Part 67 of the *Civil Aviation Safety Regulations 1998* (CASR) sets out the requirements relating to medical certification and the requirements for designated aviation medical examiners and designated aviation ophthalmologists that undertake medical assessments.

As recommended by the Aviation Safety Advisory Panel (ASAP), CASA established an aviation medicine technical working group (TWG) to review Part 67 of CASR, and to consider options based on broad industry consultation and expert advice. The ASAP supported the recommendation from the TWG for the development of a new category of medical self-declaration for pilots that are looking to conduct private operations within a safety and quality assurance framework.

To date, there have been various approaches to medical certification aimed towards providing improved access to a more contemporary and simplified medical certificate process while still ensuring safety for pilots, passengers and third parties. The introduction of the Basic Class 2 medical certificate was an initial step towards providing a medical certificate for pilots conducting private operations that was more commensurate with these operations than the other classes of medical certificates. CASA now proposes to introduce a medical self-declaration scheme that provides an acceptable level of aviation safety that is more accessible to pilots with a more streamlined process. A regulatory priority in the CASA General Aviation Workplan is the streamlining and simplification of the medical certification processes while ensuring pilots remain fit and safe to fly.

2.2 Previous consultation activities

There have been two previous public consultations:

a. December 2016 to May 2017 – The focus of this consultation was to investigate possible changes in standards for medical certification of pilots.
b. May to June 2022 – The focus of the consultation was to explore measures to simplify and modernise CASA's overall approach to medical certification.

In August 2022, the Aviation Medicine TWG considered the options for the modernisation of aviation medical certification in Australia for pilots conducting private operations in view of the industry consultation and expert advice to date. Accordingly, the ASAP recommended the introduction of a self-declaration scheme.

3 Proposed Class 5 medical self-declaration policies

3.1 Overview

The proposed new Class 5 medical self-declaration is part of an overall CASA objective to review Part 67 of CASR.

The proposed new Class 5 medical self-declaration aims to support the recreational aviation community by providing pilots who wish to conduct private operations with a more streamlined and efficient medical certification pathway. This new pathway is self-assessed and self-certified within a risk-based and quality and assurance governance framework aimed at assuring aviation safety. The Class 5 medical self-declaration is proposed to be issued through an online self-declaration process. Where a pilot is not eligible for a Class 5 medical self-declaration, they will be required to apply for an alternative class of medical certificate that can be assessed by medical practitioners against the respective CASA medical standards.

The acceptable levels of risk associated with the medical self-declaration scheme will be managed through operational limitations, medical limitations and self-declared medical assurances. (Refer to sections 3.2 and 3.3 of this PP).

The medical self-declaration scheme for the Australian context has been developed in consideration of international regulatory models that do not require review by an ICAO-approved aviation medical examiner (AME) or an assessor. There is some alignment between the CASA approach with key principles from other similar National Aviation Authorities' non-AME medical certificate models for pilots conducting private operations. Fundamentally, the difference in the proposed Australian medical self-declaration is that there is no requirement for a medical assessment by a medical practitioner or an aviation medical specialist.

This policy proposal has been developed in consultation with aeromedical technical experts and key aviation stakeholder organisations. It is also based on the principles of the Basic Class 2 medical certificate and RAMPC but has been reformed to provide a medical self-assessment and self-declaration pathway.

The Class 5 medical self-declaration offers a pathway for pilots seeking a Recreational Pilot Licence (RPL) to be able to fly for recreation, or as an entry point for those looking for a licence to be able to commence flight training, or to explore a pilot career pathway. A holder of a Private Pilot Licence (PPL) will be able to use a Class 5 medical self-declaration (noting the applicable operational limitations) instead of the currently required Class 1, Class 2, or RAMPC.

A regulatory fee of A$10 is proposed for the Class 5 medical self-declaration. The proposed fee has been determined by CASA in accordance with the Australian Government Cost Recovery Policy. CASA is required to apply this policy to its regulatory charging activities, including application fees.

The proposed Class 5 medical self-declaration scheme will:

- establish an online self-assessment and medical self-declaration for pilots seeking to conduct private operations
- manage acceptable levels of risk through operational limitations, medical limitations, and medical assurances
- provide comprehensive guidance material for applicants, certificate-holders and their health care practitioners, regarding aeromedical risk assessment for states of health and

diseases. This document is informed by the Austroads document Assessing Fitness to Drive and supported by education materials for pilots (or applicants) and healthcare practitioners.
- allow pilots successfully issued with a Class 5 medical self-declaration to access controlled and non-controlled airspace.[1]

3.2 Proposed medically related requirements and limitations

The medical requirements for the proposed Class 5 medical self-declaration are in the Attachment - *Guidelines - Medical Assessment for Aviation*. These guidelines have been developed with reference to the Austroads *Assessing fitness to drive* medical standards, with specific consideration of the flying task and the aviation environment. Unlike the Basic Class 2 and RAMPC use of the Austroads standards, the CASA Guidelines provide for flexibility based on medical advice.

Declaration for meeting the Class 5 requirements includes affirmation that the applicant:

- is 16 years of age or over to be eligible to apply and to undertake a medical self-assessment
- has referred to the *Guidelines - Medical Assessment for Aviation* to assess any safety relevant medical conditions to inform their self-assessment
- has successfully passed the knowledge examination that addresses the human factors syllabus, including medical fitness (this will be in the form of an e-learning module that will be part of the application process)
- meets the medical requirements for a Class 5 self-declaration, understands the operational limitations, and has provided true and correct information.

Factors that are expected to be considered by a pilot when making an assessment about whether their health status presents a hazard to safe air navigation include:

- the individual's knowledge about their own health (i.e., physical, mental, and emotional health) and the potential impact of their health on aviation safety
- where relevant or appropriate advice from their healthcare practitioner (e.g., GP, optometrist), on their self-assessment of state of health (in accordance with the Class 5 medical requirements and the *Guidelines - Medical Assessment for Aviation*).

It is proposed that the following medical limitations will apply. That is, pilots are **not** eligible for a Class 5 medical self-declaration if they have:

- previously had a driver's licence refused or cancelled for medical reasons[2]
- previously had a Class 1,2 or 3 aviation medical certificate refused or cancelled
- a medical condition identified in the list of excluded medical conditions for the self-declaration (see Appendix B.)[3]

[1] Australian Airspace Structure summarises the classes of airspace.
[2] Where an independent healthcare practitioner has made a medical assessment that an individual is not medically fit, the individual is not eligible to apply for a medical self-declaration.
[3] The list of proposed excluded medical conditions has been prepared with the consideration of key international self-declared models, in particular the UK PMD, Canadian Category 4 medical certificate and the New Zealand DL9 Commercial Driver's License standards.

- been diagnosed with a disease or a condition that reduces their capacity to self-assess and/or make a declaration
- been regularly taking a medication or using substances that may reduce their capacity to self-assess and/or to make a declaration
- been diagnosed with a disease or a condition that can become suddenly and unpredictably safety-relevant in the flying environment
- a medical condition that makes an individual unable to perform all required aspects or the flying task safely.

The Class 5 medical self-declaration is proposed to have a validity period of 5 years except in the following circumstances:

- Pilots over 40 years old, or with a conditional drivers' licence (including those who develop a medical condition) - a validity period of 2 years.
- Pilots 75 years old and over - an annual renewal with the requirement to provide a copy of any aged-based annual driver's licence medical review.

The Class 5 renewal will also be contingent on completion of the Class 5 medical requirements/guidance materials training package, including passing the e-learning knowledge module.

CASA recommends that the *Guidelines* developed by CASA are read in conjunction with the self-declaration certification application form. The *Guidelines* are designed to provide pilots information on the principles of aeromedical risk assessment and guidance for the assessment of medical fitness to be able to complete a medical self-assessment and to make a self-declaration. The guidelines will also guide healthcare practitioners in the provision of appropriate advice to pilots on their medical self-assessments.

In some cases, after reading the *Guidelines*, pilots may need to consult their healthcare practitioner to inform their medical self-assessment and before signing the self-declaration. Pilots are encouraged to discuss symptoms, diagnosis, and management of any medical condition(s) with their GP (or an aviation medical examiner) and the compatibility of their condition with flying. Where medical conditions are present, pilots may need to seek an alternative class of medical certificate other than the new medical self-declaration.

Applicant pilots are responsible for ensuring that their self-assessment of level of fitness to fly safely in accordance with the medical requirements and that all information provided in the declaration is true and accurate.

In accordance with the current regulatory requirements, where there is a change in safety-relevant health status, pilots are responsible for advising CASA of any change in health circumstance as soon as practical, whether temporary or longer-term impairment or incapacitation, that may impact on their eligibility for Class 5 medical self-declaration.

Where CASA determines that a pilot has made a false or misleading statement, CASA may suspend or cancel the medical self-declaration.

If a pilot's medical fitness changes and it affects their eligibility to hold a Class 5 medical self-declaration, the pilot will be prohibited from flying an aircraft until their fitness status allows them to regain their eligibility.

3.3 Proposed operational limitations

As outlined in section 3.4 below, on the basis of risk, CASA assessed that the medical limitations associated with the self-declaration required additional operational controls to provide sufficient assurance of the maintenance of an acceptable level of aviation safety. Therefore, CASA proposes to implement the operational limitations described in this section on a pilot operating under a Class 5 medical self-declaration.

These are considered the primary safety controls along with the medical limitations. The operational limitations are designed to control both the likelihood of risks occurring, and the consequences of risks if they do occur.

The proposed operational limitations are:

- aircraft certificated maximum take-off weight (MTOW) must be 2000 kg or less
- private operations only
- must only operate under the visual flight rules (day VFR) by day (no IFR, no IMC, no night VFR)
- must not operate above 10,000 ft above mean sea level
- must have no more than 2 persons on board including any crew members (generically one pilot and one passenger, or two pilots and no passengers)
- must not use a Part 61 operational rating (e.g., instructor rating or low-level rating, for a complete list, refer to the definitions in regulation 61.010 of the CASR)
- must not conduct aerobatics or formation flying
- must not operate outside Australian territory (except for flights from Victoria to Tasmania).

Appendix C provides further explanation of the operational limitations for the Class 5 medical self-declaration.

3.4 Risk assessment

The proposed self-declaration certification scheme will be managed within an appropriate risk-based governance framework that is commensurate with the type of recreational aviation activities and through the operational limitations and medical assurances.

CASA conducted multiple risk workshops and discussed the outcomes of these workshops with the Aviation Medicine TWG.

The self-declared medical assurances that are aimed at minimising safety risks, and that are in conjunction with the medical and operational limitations, include:

- comprehensive guidance materials - *Guidelines - Medical Assessments for Aviation* developed with reference to the Austroads *Assessing fitness to drive* medical standards with specific relevance to aviation safety. This includes a list of excluded medical conditions where pilots will not be eligible for the Class 5 medical self-declaration or may require a review by a healthcare practitioner.
- that a pilot has considered their health status based on the training and understanding of responsible behaviour regarding medical fitness

- where required or appropriate, advice from the pilot's treating healthcare practitioner about their health status and its safety relevance for aviation, with regard to the *Guidelines - Medical Assessments for Aviation*
- the responsibility and legal obligations of the pilot to provide a correct self-assessment and self-declaration to CASA, including that the pilot does not have any of the excluded medical conditions
- CASA's quality assurance processes to oversee implementation and identify any opportunities for improvement, e.g., guidance materials, processes, whether pilots and healthcare practitioners are using the system effectively.

Additionally, CASA also proposes to implement the following **secondary risk controls** that are acknowledged by CASA to be of lower direct effectiveness:

- implementing a relevant, reliable, and well-structured training system for healthcare practitioners
- publishing guidance material on the medical requirements for the Class 5 medical self-declaration on the CASA website
- system controls to capture whether a pilot had previously had a Class 1 or Class 2 medical cancelled or refused
- establishing an audit program to monitor the effectiveness of the implementation and quality and safety of outcomes from the Class 5 medical self-declaration.

The proposed audit program aims to support safe self-assessment, that pilots are making informed self-declarations, the risk treatments are appropriate, and that the guidance materials are effective. The proposed audit program will include:

- a proportion of Class 5 medical self-declarations will be randomly selected for audit
- selected applications being cross-referenced with CASA aviation medicine records
- some pilots being requested to provide additional supporting medical information
- reviewing Australian Transport Safety Bureau safety occurrence data based on the class of aviation medical certificate.

CASA considers that the operational limitations, in conjunction with the medical limitations, will reduce both the likelihood of a risk occurring, and the consequence if a relevant risk does occur, to an acceptable risk level.

3.5 Impacts on industry

This draft proposal has been released for formal public consultation. CASA has assessed the impacts on the aviation industry to be as described below. These assessments were informed by previous consultations concerning CASA policy and the Aviation Medicine TWG.

3.5.1 Pilots

The proposed policy is assessed to have a positive impact for private pilots who are seeking an RPL or PPL to be able to conduct private operations. With an online, self-assessment and self-declaration application process, it is expected that there will be efficiencies for pilots to obtain a Class 5 medical self-declaration. This would include access to the medical self-declaration scheme to obtain a medical to fly and the reduction of the time associated with the application

process and an issuance of a medical self-declaration. The holder of a PPL can make a Class 5 medical self-declaration and should consider the applicable operational limitations.

Guidance materials and training will be available to support pilots to undertake their medical self-assessments.

The proposed application fee of A$10 and is determined in accordance with the Australian Government charging policy, is not expected to deter applicants from applying for the medical self-declaration.

3.5.2 Healthcare practitioners

Consultation with a healthcare practitioner is optional for Class 5 applicants. However, it is anticipated that non-aviation medicine practitioners will experience an increase in pilots seeking advice to inform their fitness self-assessment and self-declaration.

The proposal policy includes providing focussed guidance, education and resource materials to applicable non-aviation medicine specialist healthcare practitioners, e.g., GPs, other medical specialists and healthcare professionals. This guidance is to assist healthcare practitioners with the provision of advice to applicant pilots in relation to their self-assessment.

Professional Colleges for General Practitioners - Royal Australian College of General Practitioners (RACGP) and the *Australian College of Rural and Remote Medicine (ACRRM)*

CASA assesses that the professional colleges for general practitioners will be required to provide increased advice on aviation medicine matters to their members. CASA intends to consult with the colleges on how they can best support the proposed policy, in accordance with the broader communication strategy.

3.5.3 Sport Aviation Bodies

The proposed policy does not alter the self-declaration medical scheme utilised by some Sport Aviation Bodies (SAB).

If adopted by the SABs, the CASA Class 5 medical self-declaration offers an alternative medical certification option for SAB pilots conducting operations under the auspices of the SAB.

Appendix A outlines the differences between SAB self-declaration medical and the Class 5 medical self-declaration.

3.5.4 Insurance companies

The proposed policy may be of interest to the Insurance Council of Australia and insurers, who may wish to consider the currency of the terms and conditions of their policies offered to pilots that seek a Class 5 medical self-declaration, for example if there is a misrepresentation or an understatement of their health status.

3.5.5 Flight Training Schools/Flight Instructors

CASA assesses that flight training schools and flight instructors will be required to provide increased support to pilots through the provision of information on the Class 5 medical self-declaration.

Flight schools and flight instructors will have access to the Class 5 guidance and education materials and focussed training modules.

4 Proposed implementation of the policy

4.1 Short term activities

If CASA proceeds with this policy proposal after this consultation activity, the initial implementation activities would include the following:

- creating an appropriate exemption from existing regulations
- modifying relevant IT systems to facilitate the online application process and issuance of a CASA Class 5 medical self-declaration upon the successful completion of an application
- publishing the final Guidelines and other Class 5 medical self-declaration guidance and education materials on the CASA website
- exploring options for provision of guidance materials and other relevant resources to ensure they are accessible regardless of geography or access to the internet
- establishing the quality assurance program for the Class 5 medical self-declaration, such as the proposed audit program and post-implementation review.

4.2 Transition strategy

The following will be considered as part of the transition strategy for the new policy:

- a communication strategy that identifies all impacted stakeholders
- Medical Records System enhancements to support the new Class 5 medical self-declaration
- education and guidance materials for potential pilot applicants to ensure they are well informed to be able to apply for a Class 5 medical self-declaration and can undertake a self-assessment, including those pilots who may hold a current Basic Class 2 medical certificate or a RAMPC
- guidance materials and resources for healthcare practitioners who may provide advice to an applicant on their self-assessment of fitness in accordance with the *Guidelines - Medical Assessment for Aviation*
- the implementation and ongoing delivery of the quality and assurance framework[4]
- any potential consequential impacts from the implementation of the policy.

The following is the proposed transition arrangements for the Class 5 medical self-declaration:

- Once the new self-declaration certification policy is in effect, any pilots that wish to continue to apply for a Basic Class 2 medical certificate or RAMPC can do so. However, pilots will be given the opportunity to apply for a Class 5 medical self-declaration. It should also be noted that the RAMPC and Basic Class 2 certificate may be subject to change in light of other reforms CASA is considering for the aviation medical scheme, including a proposed Class 4 medical certification and the related reform amendments to CASR.

4 The quality and assurance framework is an integrated part of CASA's corporate governance structure which supports decision making and accountability.

- For those pilots who have a current Basic Class 2 medical certificate or RAMPC, the duration of their medical certificate will remain unchanged, and they will be able to apply for a Class 5 self-declaration certification when they need to renew their medical certificate.
- Upon the commencement of the new policy, pilots who have recently applied for a Basic Class 2 medical certificate or RAMPC, will be contacted and guided to information about the new Class 5 self-declaration certification and will have the opportunity to change the category of their medical certificate.
- Holders of an expiring RAMPC or Basic Class 2 medical certificate before the commencement of the Class 5 self-declaration certification will be advised about the option to apply for the new Class 5 medical self-declaration when the scheme commences.

4.3 Medium term activities

Follow-on activities in the medium term would include:

- conducting appropriate consultation and associated activities for the proposed Class 4 medical certification that will permit more operations than Class 5 (anticipated by late 2024) but will require a GP medical examination. The Class 4 medical certificate is proposed to replace the Basic Class 2 medical certificate.
- additional amendments to regulations previously identified in the aviation medicine policy review that support other reforms to the aviation medical certificate structure (anticipated for 2025/2026)
- proposed development of a Part 67 MOS in due course to support the broader amendments to the aviation medical certification structure referenced in Part 67 of CASR, including the amendment of the regulations to replace the RAMPC with the Class 5 medical self-declaration.

4.4 Post Implementation Review

A comprehensive post-implementation review (PIR) of the policy is planned within 12 months of the commencement of the proposed new policy. The PIR will be an opportunity to review and consider the effectiveness of the policy. It is proposed that a further PIR will be undertaken 2 years after implementation that will include a comprehensive safety impact assessment of the implementation.

It is expected that the PIR will also inform the consideration processes for the proposed Class 4 medical certification.

5 Closing date for comment

CASA will consider all comments received as part of this consultation process and incorporate changes to the proposed policy as appropriate, Comments on the policy proposal should be submitted through the online response form by close of business **17 November 2023**.

Appendix A

Medical certificate comparison tables

A.1 Table 1a – Australian certificates, medical

Medical	CASA Class 5 (proposed) ~ Indicates dissent with TWG	RAAus	Basic Class 2	RAMPC
Eligibility	~Never had a driver's license cancelled for medical reasons. Does not have any of the listed excluded conditions. Has completed mandatory online knowledge check.	Any.	Not eligible if they have previously had a CASA Class 1, 2 or 3 medical certificate suspended or cancelled.	Any.
Doctor involvement	Not required. Recommended that advice be sought per guidance material.	Not required, except: • At age 75, and if any of the listed medical conditions, and if instructing.	Examination by any medical practitioner.	Examination by any medical practitioner.
Processes and forms	Pilot completes declaration. No excluded conditions. Have referred to and followed medical guidance. Are eligible as above. Class 5 medical self-declaration is auto-issued by CASA.	Self-declaration - RAAus Medical Declaration (Form MED002) OR Exam (GP) for certain listed medical conditions (form MED 001) OR Exam (GP) for instructors (Form MED003) – Commercial Driver License Standard. Pilot submits the declaration form and doctors form (if needed) with their BFR (every 2 years). No certificate issued.	Pilot downloads the form (pilot questions, doctor questions, doctor examination – Form 1743, 1474, 1475). Doctor completes paper forms and signs. Pilot completes declaration in MRS. CASA issues the exemption from holding a Class 2 medical certificate.	Pilot downloads the form (pilot questions, doctor questions, doctor examination). Doctor and pilot complete paper form (Form 166). Doctor issues the certificate.

Medical	CASA Class 5 (proposed) ~ Indicates dissent with TWG	RAAus	Basic Class 2	RAMPC
Medical standard	Guidance material only. Guidelines - Medical Assessment for Aviation with a range of disqualifying criteria.	AFTD private drivers license. AFTD commercial drivers license for instructors.	Austroads medical standards (unconditional) for commercial motor vehicle drivers (excludes glasses and hearing aids).	"Modified Austroads Standard" - Austroads medical standards (unconditional) for private motor vehicle drivers with some additional CASA disqualifying criteria.
Excluded conditions	Diseases causing impaired capacity to declare (dementia, psychosis etc), or diseases with unpredictable and unheralded incapacity (seizures etc). Significant examples listed on the class 5 medical self-declaration form.	None specified.	None specifically.	Listed on RAMPC Form.
Validity period	Every 5 years to age 40 then every 2 years thereafter. 1 year for age 75 years and over.	Every 2 years.	1 year for age 70 years and over. 2 years for age between 40-69.	Certificate duration: • 1 year for age 65 years and over • 2 years for age under 65.

A.2 Table 1b – Australian certificates, operational

Parameter	CASA Class 5 (proposed) ~ Indicates dissent with TWG	RAAus	Basic Class 2	RAMPC
MTOM/MTOW	2000 kg	600/650 kg (water/non water). Up to 750 kg on application.	<8618kg	1500kg
POB	~2 (pilot + 1 pax)	1 2 (pilot + 1 pax) only with PAX endorsement.	6 (1 pilot + 5 pax).	2 (pilot + 1 pax).
Aircraft type	NS	2 seats. 3-axis, weight shift, powered parachutes.	Piston engine only.	Single engine piston.
Power/speed	NS	NS	NS	NS
VFR/IFR/Day/Night	Day VFR only	Day VFR only	Day VFR	Day VFR
Operational ratings/flight activity endorsements	~No aerobatics ~No formation No low-level rating No instructor rating	Formation with endorsement. Low level with endorsement.	No operational ratings. No flight activity endorsements.	No aerobatics
Altitude	~10,000 ft	10,000 ft (not below 500 ft)	10,000 ft	10,000 ft
Air space	Access to controlled and non-controlled airspace.	Not in controlled areas.		

Parameter	CASA Class 5 (proposed) ~ Indicates dissent with TWG	RAAus	Basic Class 2	RAMPC
Other authorisations	NS	Cross-country, radio operations, Glider towing, Tail wheel, 2-stroke, adjustable propellor, retractable undercarriage, floats, utility with endorsement.	These restrictions do not apply if a qualified pilot in the control seat has a valid Class 1 or Class 2 medical certificate.	The airspace, passenger and aerobatic restrictions do not apply if the pilot in a control seat: • is suitably qualified • aerobatic flight endorsed (if relevant) • has a valid Class 1 or Class 2 medical certificate.

A.3 Table 2a – International certificates, medical

Parameter	UK PMD-2000	UK PMD-5700	UK LAPL-Med	Canada Cat 4	NZ DL-9	US BasicMed
Eligibility	Must already have a license (and med cert). Not taking medication for any psychiatric illness.	Must already have a license (and med cert).	Any.	Never been refused on medical grounds a motor vehicle license, aviation permit, or life insurance.	Any.	Must hold a valid state driver's license and have held FAA medical cert since 2006 (not suspended or revoked).
Doctor involvement	Not required. (Dr involved in initial medical assessment to be eligible for subsequent pilot medical declaration (PMD)).	As needed: • AME for PMD, other doctors as required for driver and vehicle licensing agency (DVLA), and initial certificate • Mandatory reporting by app to DVLA where the DL standard is not met (and doctor authorised to report)	Required for every certificate. Mandatory reporting by app to DVLA where the DL standard is not met (and doctor authorised to report).	Required for every certificate.	Not mandatory medical may be conducted by Medical practitioners, nurse practitioners or registered nurses. App must notify Medical professional that the DL9 will be used for flying. Mandatory reporting by Medical practitioners, nurse practitioners or registered nurses to CAA NZ and NZTA/Waka Kotahi.	Required for every certificate.
Processes and forms	Pilot completes affirmation of their reasonable belief that they meet the requirements for a DVLA car license.	PMD requires affirmation by pilot of reasonable belief that they meet the DVLA Group 1 (car) license standard, AND If any of the below	Doctor issuing certificate must be a GP. Medical examination if aged over 50 years and for first light aircraft pilot licence (LAPL)	Physician attestation that the pilot's medical declaration is accurate.	Comprehensive clinical examination (NZTA guidance. DL9 form completed.	State-Registered medical practitioner completes form 8700, plus any state driving license medical requirements. Comprehensive

Parameter	UK PMD-2000	UK PMD-5700	UK LAPL-Med	Canada Cat 4	NZ DL-9	US BasicMed
		apply (or if unsure), pilot must consult with an AME.	application. AME review for medical conditions; See GP guidance.			Medical Examination Checklist. Supply 3 years of medical records.
Medical standard	DVLA Group 1 (car).	DVLA Group 1 (Car License).	LAPL medical conditions.	Physicians are referred to Handbook for CAME.	NZTA Driver License Class 2 (2,3,4,5) = Commercial with Passenger endorsement.	Have previously held FAA Class 3 (PPL) medical. Physicians are referred to FAA Class 3 (PPL) standards.
Excluded conditions	Medication for a psychiatric illness.	Extensive list requiring AME review.	Extensive list requiring AME review.	Never suffered from any of the listed medication conditions.	Must declare any medical conditions that may affect your ability to drive safely.	Require special issuance if following list of medical conditions.
Validity period	Valid to age 70 unless a reason to withdraw the declaration or DVLA restriction. Every 3 years after age 70.	Valid to age 70 unless a reason to withdraw the declaration or DVLA restriction. Every 3 years after age 70.	Every 5 years under age 40 (to 42nd birthday); every 2 years from age 40.	Every 5 years.	Every 5 years up to age 40, every 2 years from 40+.	Every 4 years with doctor, every 2 years for BasicMed medical training course.

A.4 Table 2b – International certificates, operational

Parameter	UK PMD-2000	UK PMD-5700	UK LAPL-Med	Canada Cat 4	NZ DL-9	US BasicMed
MTOM/MTOW	2000 kg	5700 kg	2000 kg	NS	2730 kg	6000 lb (2721 kg).
POB	4 (pilot + 3 pax)	4 (pilot + 3 pax)	4 (pilot + 3 pax)	2 (pilot + 1 pax)	6 (pilot + 5 pax) unless aeros (solo).	6 (Pilot + 5 others).
Aircraft type	Part 21 and non-Part 21.	Part 21 and non-Part 21.	Single engine piston land, A or H, or touring motor glider.	Glider, ultralight or recreational aeroplane (land or sea), single engine, non-high-performance. 4 seats or less.	Aeroplane and helicopter. No gliding (must have a Class 2).	No more than 6 occupants.
Power/speed	NS	NS	NS	NS	NS	250 KIAS
VFR/IFR/Day/Night	VMC; IMC for PPL(A); night rating if colour normal; no IR.	VMC; IMC for PPL(A); night rating if colour normal; no IR.	VMC; IMC for PPL(A); night rating if colour normal; no IR	Day VFR.	Night only within 25 nm of a lit aerodrome. No IFR.	VFR and IFR.
Operational ratings/flight activity endorsements	NS	NS	NS	Not permitted except for float rating.	Aerobatics only solo above 3000 ft.	NS
Altitude	NS	NS	NS	NS	25000 ft AMSL	18000 ft AMSL
Air space	NS	NS	NS	Not in controlled areas	Permitted in controlled areas if radio contact maintained OR has passed the colour vision test.	NS

Parameter	UK PMD-2000	UK PMD-5700	UK LAPL-Med	Canada Cat 4	NZ DL-9	US BasicMed
Other authorisations	NS	NS	NS	NS	Cross county and Helicopter sling loads if flight training completed. Banner and drogue tow only above 500 ft. Parachuting not above 10000 ft. Glider towing only under control of a gliding organisation or adventure aviation operator.	Not for instructing.

Appendix B

Proposed excluded medical conditions - Class 5 medical self-declaration

As part of the risk management strategy and medical assurances, it is proposed that there is a list of medical conditions that **are ineligible** for a Class 5 medical self-declaration ("Class 5").

At the core of self-assessment for self-declaration are three critical elements:

1. The ability to reflect on personal health and wellbeing (How do I feel? Does the way I feel present a hazard to safe flying?)
2. To understand the details of symptoms, diagnosis and treatment (How bad is my disease? How much does it affect me? How do these medications make me feel? How much do they affect me?)
3. Predictability or reliability of that assessment for the flight (can the way I feel or the status of my disease change while I'm flying in a way that is unsafe and can't be predicted?).

While the guidance material and advice from healthcare practitioners will contribute towards the management of the second element, the capacity to self-assess and the reliability of that self-assessment are things that an individual may not necessarily be able to manage. For these reasons the aviation technical experts and TWG have proposed that an additional layer of medical assurance be added to the Class 5 that manages these issues.

The Class 5 proposal has been developed in consideration of the key principles of other international aviation regulatory models, such as the UK and New Zealand medical certificate. However, the proposed Class 5 medical self-declaration scheme does not require a medical examination by a medical/healthcare practitioner.

Where the medical conditions listed below are present, the pilot is **not eligible** for a Class 5, although they may be eligible for another Class of medical certificate. Pilots should discuss their symptoms, diagnosis and management with their GP or an aviation medical examiner to discuss whether and how their condition might be compatible with flying.

Pilots are **not eligible** for a Class 5 if any of the following apply:

1. If they have previously had a driver's licence medical certificate refused or cancelled.
2. If they have previously had a Class 1, 2, or 3 aviation medical certificate refused or cancelled.
3. If they have been diagnosed with a disease or condition that reduces their capacity to self-assess and/or to make a declaration *(This aligns with the private driver's licence medical standard - drivers with these diseases must see a doctor to assess their memory and cognition)*:
    a. Dementia or other memory disorders:
        i. For example, Alzheimer's disease, vascular dementia, Lewy Body dementia.
    b. Psychotic disorders or psychiatric diseases with psychotic features:
        i. For example, schizophrenia, bipolar disorder.
    c. Any other disease which includes cognitive impairment or decline as a known part of the natural history of the disease:
        i. For example, Parkinson's disease, traumatic brain injury.

4. If they are currently regularly[5] taking a medication or using substances that may reduce their capacity to self-asses and/or to make a declaration:[6]
    a. Benzodiazepines and other sedatives
        i. For example, diazepam, alprazolam.
    b. Antipsychotics
        i. For example, olanzapine, quetiapine, aripiprazole.
    c. Tricyclic antidepressants
        i. For example, amitriptyline.
    d. Mood stabilising medications
        i. For example, lithium, sodium valproate.
    e. Narcotic analgesics
        i. For example, hydromorphone, codeine, morphine, oxycodone.
    f. Pain-modifying medications.
        i. For example, gabapentin, pregabalin.
    g. Drugs whether illicit or prescribed - anything that would lead to a non-negative initial result on a DAMP test, or be considered as problematic use of substances or a substance use disorder.
        i. For example, dexamphetamine, THC, alcohol dependence.
    h. Any medication that causes the pilot to have an alteration in sensory function, motor function or cognition.
5. If they have been diagnosed with a disease or a condition that can become suddenly and unpredictably safety-relevant in the flying environment:[7]
    a. Epilepsy and other seizure disorders, or diseases that could cause seizures.
    b. Blackouts or other sudden alterations of consciousness, or diseases that could cause these.
    c. Insulin-treated diabetes.
    d. High-risk pregnancy.
    e. Lung disease that requires oxygen therapy.
    f. Intracranial malignancies.
6. If they have a medical condition that makes them unable to perform all required aspects of the flying task safely[8]:
    a. Visual field or visual acuity that does not meet the private driver's license standards.
    b. Hearing loss that means they are unable to understand conversational voice at a distance of 2 m.
    c. Neurological or musculoskeletal or other functional impairment that causes them not to be able to operate the flight controls safely in all circumstances.

[5] Regularly means taking the medication most days, and/or the disease or symptoms will become significantly worse if the medication is not taken on most days.

[6] This aligns with the private driver's licence standard - drivers with these diseases must see a doctor to assess the impact of their disease and their medication's effects on their ability to perform the required tasks safely.

[7] This aligns with the private driver's licence standard - drivers with these diseases must see a doctor to assess the nature and likelihood of these diseases causing them to be suddenly unable to safely perform the required tasks.

[8] This aligns with the private driver's licence standard - drivers with these conditions must see a doctor to assess their vision, hearing, and their physical functions.

If a pilot is unsure if they have a certain diagnosis, or they are unsure if their disease is severe enough to be safety-relevant, or they are unsure if their medication is of concern, they will be expected to seek advice from their GP or an aviation medical examiner before making a self-declaration.

Appendix C

Proposed operational limitations for the Class 5 medical self-declaration

The proposed operational limitations for Class 5 medical self-declaration pilots have been developed in consultation with the Aviation Medicine Technical Working Group (TWG). They have been developed through a comprehensive risk analysis process that is aimed at managing the increased likelihood of a Class 5 pilot having a medical impairment by mitigating the consequences of an accident in the air and on the ground. The mitigation strategies identified cover the type of aircraft, type of operations, number of people exposed, medical guidelines and excluded medical conditions, and quality assurance processes to validate the risk assessment process.

The proposed medical self-declaration scheme is a leading initiative and there is no known equivalent non-Aviation Medical Examiner medical self-declaration regulatory model. This means that there is no comparative data in Australia or internationally to quantify the likelihood of impairment, or the likelihood of an impairment-related accident, where pilots have not been assessed by a medical practitioner. The available data on doctor-issued (non-AME) certificates in aviation and road standards, with which the Class 5 medical guidelines are aligned, indicate that the Class 5 pilot population is likely to have between 5 times and 10 times the likelihood of impairment compared with the Class 2 medical examiner-certified pilots. The collection of impairment data for Class 5 medical self-declaration is a critical element in identifying and quantifying the likelihood and the impairment risk[9] for our population, to ensure our assessment is correct.

Air safety occurrences require mandatory reporting under the *Transport Safety Investigations Act 2003.* Class 5 medical self-declaration pilots will be required to report on any medical issue in flight that caused them to have reduced capacity to control the aircraft for any period of time, or a change to the flight plan due to an issue, such as land early, divert, change altitude, hand over control to another pilot. CASA will collaborate with ATSB to ensure this data is reliably captured for Class 5. The safety occurrence data will inform the safety and risk assessment element of the PIR.

The material below is intended to provide some further explanation of the rationale for some of the operational limitations.

1. **Maximum Take-off Weight (MTOW)** – the proposed certificated maximum take-off weight of no greater than 2000 kg is aligned with the UK CAA MTOW requirements for their Pilot Medical Declaration.

   The proposed MTOW of 2000 kg is desirable from a private pilot perspective as it captures the majority of aircraft on the Australian Register that would be operated by a private pilot. It is desirable from a hazard reduction perspective as it reduces the number of complex aircraft (multi-engine or high-performance) within scope which reduces the cognitive load on a subject pilot.

2. **People on Board (POB) –** the proposed limit of 2 persons (pilot and 1 passenger) on board is aligned with the limitation for RAAus self-declaration with passenger endorsement, and the CASA RAMPC.

   This is desirable from a risk reduction perspective as it limits the number of directly affected persons as a consequence of pilot incapacitation, which is a higher risk under the Class 5 medical self-declaration scheme than under other CASA medical certification

[9]US FAA BasicMed review, 12% annual risk of death from all causes in BasicMed holders. AFTD and UK DVLA private driver impairment risk threshold = 20% per annum. Class 2 solo pilot risk threshold = 2% per annum.

options. However, it should be noted that the number of indirectly affected persons as a result of pilot incapacitation could be significantly higher if other aircraft or persons on the ground are impacted by an adverse incident.

3. **Altitude 10,000 ft** – the proposed altitude ceiling is a risk treatment for aeromedical conditions i.e.**,** hypoxia. It is consistent with the limit for RAAus, RAMPC and Basic Class 2 medical certificate.

   Oxygenation of tissues requires the transfer of oxygen from the atmosphere to the body's cells, using a number of physiological steps. A critical determinant of gas transfer from atmosphere all the way through to cells is partial pressure of oxygen. At 10,000 ft, the partial pressure of oxygen goes below that which is required for effective gas transfer in healthy adults at rest, noting that pilots conducting their duties are definitely not 'at rest'. At 10,000 ft these healthy adults start to experience impairment of executive function and increasing demands on their cardiac and respiratory systems. If the person has a health state, disease or medication that reduces the transfer of oxygen in lungs and tissues, circulation of blood to tissues, carriage of oxygen in haemoglobin or red blood cells, or increased tissue oxygen demand compared with a resting healthy adult, they will experience the onset of impairment of executive function and increased cardiorespiratory demand at less than 10,000 ft.

   Pilots with cardiac, respiratory, and neurological diseases will be more impaired by hypoxia from 5,000 ft upwards and will certainly be significantly impaired by 10,000 ft (below PaO2 50mmHg, SaO2 <90%). Guidance material will advise pilots to seek advice from doctors about whether they should self-limit at a lower altitude.

4. **Access to airspace –** proposed access to controlled and non-controlled airspace.

   While safety remains paramount, CASA is required to foster efficient airspace use and equitable access to airspace for all users when administering Australia's airspace. The proposed access for Class 5 pilots to controlled and non-controlled airspace follows risk assessment and consultation with CASA technical experts and the TWG.

   A pilot licensed under Part 61 of CASR must demonstrate competencies before operating in controlled airspace (CTA). Operating in controlled environments is more structured and formal, more demanding and with an increased emphasis on safety awareness and willingness to self-report errors or any inability to comply with Air Traffic Control instructions.

   Permitting access to CTA is intended to reduce the likelihood of mid-air collision or collision with terrain and reduce the number of fatalities in aircraft and on the ground in the event of these occurrences. This will be done using the existing Airservices Australia systems to maintain separation and manage aircraft movements.

   The issue of access to CTA will be reviewed as part of the post-implementation review of the Class 5 scheme.

5. **No aerobatics** – further to a risk assessment of likelihood and consequence of risks of incapacitation in-flight and to ensure there is a risk control in place, it is proposed that Class 5 medical self-declaration pilots are not permitted to conduct aerobatics.

Aerobatic manoeuvres subject the pilot to +Gz ("G") forces which incur significant physiological burden. Aerobatically-capable civil aircraft can expose pilots to up to 9G (modern military aircraft approach 15G). G tolerance varies based on the rate of onset, peak G levels, the use and effectiveness of the anti-G straining manoeuvre, G-protection equipment and pressure breathing. G tolerance also varies based on the pilot's cardiac function, respiratory function, muscle strength and endurance, hydration status, fatigue status and cerebral perfusion. Exposure to G can also cause impairment of cardiac and respiratory function, visual function, or balance and orientation function will reduce G tolerance and increase risk of spatial disorientation.

Fatal accidents are more likely to be the consequence of aerobatic manoeuvres as the incapacity is likely to be G-LOC, A-LOC or SD and therefore not likely to be recoverable even from higher altitudes.

6. **No formation flying** – further to a risk assessment of likelihood and consequence of risks and to ensure there is a risk control in place, it is proposed that Class 5 medical self-declaration pilots are not permitted to conduct formation flying.

   Formation flying relies on the pilot's ability to maintain separation from another aircraft in close proximity. This requires effective function of the visual system around depth perception, visual acuity and visual fields, plus effective integration of the visual system with executive functions to rapidly and accurately respond to time-critical aircraft, pilot and environmental cues. An assessment by a suitably trained clinician using specialised tools and processes is required, which is not part of the Class 5 medical self-declaration scheme.

   Any impairment to visual function, including peripheral field functional deficits, field deficits, and depth anomalies will reduce the ability to fly the sortie as briefed (short term memory and learning deficit due to impaired executive function), maintain separation (visual field and depth function, and executive function in time-critical responses to evolving flight situation).

   Aircraft in pre-planned close proximity have a significantly lower capacity to tolerate errors from pilots, whether generated from a medical issue or otherwise.

   The consequence of mid-air collision during formation flying due to loss of separation is more likely to be unrecoverable and result in loss of multiple aircraft and/or severe or fatal injuries to multiple occupants.

7. **Day VFR only (not IFR, IMC or night VFR)** – this is a measure to mitigate potential risks of an accident or serious incident as a result of in-flight visual dysfunction during flight.

   The normal operation of the visual system requires the absence of disease or dysfunction of the extra-ocular muscles, cornea, pupil, lens, retina, optic nerve, optic tracts and optic cortex and executive function integration. Most of the diseases of the visual system (such as cataract, glaucoma, macular degeneration, hypertensive and diabetic retinopathy, require comprehensive assessment by an appropriate clinician with specialised equipment.

Aviation Safety Committee Paper

ASC Meeting No.51

Agenda Item:	**TBA**
Board Action:	**Decision**
Subject:	**Class 4 Aviation Medical Certificate Model**
Origin:	[ASC action item?]
Prepared by:	SED (CSC-Avmed-PMO)

Desired Outcome:

1. ASC endorse the progression of work towards the proposed Class 4 aviation medical certificate under Part 67 with a view to implementation by instrument in late 2023.

Executive Summary:

2. A self-declared aviation medical certificate under Part 67 of CASRs is an important step in the modernisation of recreational aviation medical certification in Australia. For safe and effective implementation in a timely manner, CASA Avmed proposes a Class 4 self-declared medical certificate using a of a fit-for-purpose standard that is augmented by a decision-making pathway for flexible application by the pilot's suitably qualified Specialist GP.

Background:

3. Multiple rounds of consultation with stakeholders and participants in the Australian private and recreational aviation community over the last two decades have identified the importance of a self-declared aviation medical certificate. Stakeholders have sought alignment with other similar regulators including FAA, CAA UK, CAA NZ and CAA Canada. While each of these regulators' models has merits, none of them have the scope and flexibility that CASA is seeking. Attachment A details the differences in the key medical certification features of private and recreational type certificates, demonstrating the benefit of the CASA proposed approach.
4. Various approaches to self-declared medicals over the last two decades have been implemented external to Part 67 in an attempt to provide an accessible, flexible and safe recreational aviation medical certificate. These include the RAMPC, Basic Class 2 exemption and fitness assessments by ASAOs. Each of these have not been able to entirely deliver the desired outcomes, partly because they have not been supported by the comprehensive governance and implementation system that is provided with Part 67 medical certificates. As part of the reform of Part 67, a new "Class 4" self-declared aviation medical certificate is proposed to be formalised within the regulations, which will provide these extra layers of safety needed to support accessibilty and flexibility.
5. The Aviation Medicine TWG has considered options based on broad industry consultation and expert advice. Their recommendation is of a self-declared Class 4 within a strong framework of safety and quality assurance. The framework proposed by CASA Avmed to deliver this includes:
    a. development of a fit-for-purpose recreational aviation medical standard aligned with the private motor vehicle standards,
    b. simple and clear advice for users of this standard for self-declaration,
    c. pathways for escalation of decision-making to Specialist General Practitioners (SGPs) or to CASA for certification,
    d. focused training for SGPs with clear directions for application of the flexible recreational aviation medical standard, and

e. assurance of the safe and effective use of the Class 4 certification process through CASA audit and oversight.

6. This approach allows Australia's version of the recreational aviation medical certificate to be more flexible and therefore more widely accessible by the general aviation community than those available in the jurisdictions listed above. Uniquely, CASA's approach will mean that the pilot's assessing SGP will be able to work with CASA and independent aerospace medicine specialists to apply a more flexible standard and make this certificate accessible even to pilots with medical conditions that would be excluded internationally. The proposed pathway for the Class 4 medical certificate is outlined in Attachment B.
7. Operational considerations are critical to the safe implementation of the Class 4. Appropriate but not excessive operational restrictions will balance the increased acceptance of medical risk, to achieve an optimal outcome that permits the majority of recreational pilots to undertake the majority of recreational activities. The scope of operations has been determined through a series of focused risk-assessment workshops within CASA, referencing existing licensing and certification restrictions and those of other jurisdictions, and set within the CASA Board's regulatory risk appetite and Australia's aviation safety system obligations.
8. Second-order benefits of the introduction of this Class 4 certificate include the potential transfer of significant numbers of private pilots from Class 2 across to Class 4. This may result in an improved capacity for CASA and authorised DAMEs to issue Class 1, 2 and 3 certificates. Further secondary benefits include readiness in advance for a likely move by ICAO towards a recreational aviation medical certificate, and readiness for delegation of more complex cases to non-CASA aerospace medicine specialists.
9. Introduction of the Class 4 medical certificate in this proposed form has the broad support of all major stakeholders and participants and will deliver an important outcome for the recreational aviation community. Delaying introduction until the making of the new Part 67, likely to be in 2025, will not provide any additional benefit from a safety or legislative perspective, but will erode confidence and goodwill within the industry. It is therefore proposed that the Class 4 medical certificate is implemented by instrument in 2023, after development of the above systems and processes, and subsequently incorporated in the new Part 67.

Recommendation:

It is recommended the ASC **approve** the development of the proposed Class 4 recreational medical certificate and supporting governance systems and policies, for implementation by instrument in 2023.

Proposed Resolution:

The ASC approved the development of the proposed Class 4 recreational aviation medical certificate and supporting governance systems and policies, for implementation by instrument in 2023.

Prepared by: Dr Kate Manderson, Principal Medical Officer

Approved by: Andreas Marcelja, EM SED

Date: Day/Month/Year

Attachments:

A Class 4 Comparison Tables

B Class 4 Pathways to Certification