Australian Government
Civil Aviation Safety Authority

SUMMER 2007-08

DAMEnewsletter

UPCOMING EVENTS FOR YOUR DIARY

16 - 27 FEBRUARY 2008
AMSVIC
Antarctic Study Expedition
(departing Ushuaia)

9 MARCH 2008
Aviation Medicine NSW Seminar
~~Corrigal~~ CANCELLED

MAY 2008
ASMA
Annual Scientific Meeting
Boston

2008 (TBA)
ICASM
Bangkok

8 – 9 NOVEMBER 2008
NSW Annual Seminar
Sydney
– Special guest Hugh O'Neil former medical director of Transport Canada

IN THIS EDITION:
ALCOHOL & OTHER DRUGS – TESTING PROCEDURES

PMO's Column

As 2007 approaches its end, it's time to reflect back on a year that for CASA's office of aviation medicine has been a busy and challenging one, but also has been productive and rewarding. It is also an opportunity to look forward to 2008, which promises to be equally as challenging.

Along with the ongoing project to review and improve CASA's online medical records system, the biggest challenge of 2008 will be the introduction of CASA's programme for the management of alcohol and other drug (AOD) safety issues within the Australian aviation industry.

Accordingly, I have dedicated a significant proportion of this edition of the DAME newsletter to coverage of CASA's intended programme and to how it might relate to DAMEs. The timing in relation to the upcoming festive season is purely coincidental.

It is important that DAMEs are aware of the programme and are well placed to assist and advise certificate holders and other safety-sensitive aviation personnel in relation to the introduction of the project. As well as providing medical advice on the implications of the programme to certificate holders, some DAMEs may provide testing services or act as Medical Review Officers (MROs) for organisations that will be required to conduct AOD testing of their safety sensitive employees.

Some DAMEs may also act as a substance misuse professional for review-and-monitoring personnel identified as having an AOD problem. Various parts of this newsletter are therefore devoted to the technical, clinical and administrative issues that the programme raises.

Avmed now has overall responsibility for the delivery of the AOD project and so a number of initiatives are under way to ensure a robust, evidence-based programme is in place and that

the policy and regulations reflect the primary goal of the programme, which is safety.

We have enlisted a project manager, Ms Brenda Cattle, to coordinate the implementation. Brenda has a post graduate toxicology degree and has extensive experience in the implementation of workplace AOD testing, having previously managed the drug and alcohol program for Patrick (now part of Asciano Limited).

Another key element of the programme is education and to ensure that CASA provides all stakeholders with access to high quality reliable information, Avmed has retained the services of Ms Donna Bull, who holds a Bachelor of Social Sciences, and Masters of Social Sciences and Social Policy and is the former Chief Executive Officer of the Alcohol and other Drugs Council of Australia (ADCA). Donna also holds the position of Senior Specialist Adviser on Alcohol, Tobacco and Other Drugs to the Australian Defence Force (ADF).

Together, Brenda and Donna have decades of experience working in the alcohol and other drugs sector in a variety of roles, including workplace drug testing, program development and evaluation, health promotion, client service delivery and policy making.

On the medical aspects of AOD, there has also been some progress with Dr Fitzgerald and myself, successfully completing qualification as Medical Review Officers (MROs) under the auspices of the North American MROCC. The role of the MRO is expanded upon below. A successful visit to Washington D.C. was also completed to liaise with the FAA and try and glean some of the lessons they have learned over the past 20 years of their programme.

In mid-November, a joint regulatory meeting was held with NZ CAA, with the aim of further developing guidance material on how AOD issues in certificate holders are best dealt with from a regulatory perspective.

The US HIMS model was examined as one successful joint industry-employee-regulatory approach.

In closing, I wish all a safe and enjoyable festive season and a happy and successful 2008.

– Dr Ian Hosegood

OVERVIEW OF CASA'S ALCOHOL AND OTHER DRUG PROGRAMME

Background

The decision for the introduction of this programme was based on a joint report prepared by the Department of Transport and Regional Services and the Civil Aviation Safety Authority (CASA) into the safety benefits of introducing drug and alcohol testing for safety sensitive aviation workers and is available on the CASA website at www.casa.gov.au/newrules/special/drugtesting/index.asp

The programme has two components

The first is an aviation industry component consisting of Drug and Alcohol Management Plans (DAMPs), implemented by the holders of Air Operator Certificates and Certificate of Approval holders, but subject to audit, oversight and monitoring by CASA.

It is expected that this component will capture an approximately 67,000 employees in aviation safety-sensitive roles and is planned to be implemented later in 2008, subject to necessary amendments to the Civil Aviation Safety Regulations.

The introduction will be supported by a comprehensive industry wide education and awareness campaign and training in the development of Drug and Alcohol Management Plans for these organisations. DAMP organisations will be required to implement pre-placement, reasonable cause, return to work and post-incident testing but not necessarily be required to do random testing.

The second component, starting in the first quarter of 2008 is the introduction of a scaleable random testing regime undertaken by a CASA testing provider. Those subject to testing will include flight crew, cabin crew (flight attendants), flight instructors, aircraft dispatchers, aircraft maintenance and repair personnel, aviation security personnel including screeners, air traffic controllers, baggage handlers, ground refuellers and other personnel with airside access.

It is proposed that this regime cover all safety sensitive personnel, including those not captured under the commercial scheme. This group includes private pilots, contractors and all those undertaking safety-sensitive aviation activities with a total coverage of approximately 120,000 personnel.

For private pilots, this testing is analogous to roadside random drug alcohol testing undertaken by police and for the DAMP organisations, the random CASA testing is to measure the success of those programmes.

Implementation

Amendments to the Civil Aviation Act 1988 were made in August 2007 to ensure that CASA is able to implement the programme. The Act amendments

also provide a head of power for the development of regulations to implement a broad ranging, random testing regime covering all safety sensitive personnel. Drafting of the regulations has commenced and final policy instructions are currently being prepared.

The aim of the programme is prevenative, not punitive. However, the regulations will be supported by a suitable enforcement regime to deal with persons whose test results return confirmed positive readings over the acceptable levels for drugs or alcohol.

TESTING PROCEDURES FOR ALCOHOL & OTHER DRUGS

What substances will be tested?

- Delta-9-tetrahydrocannabiol (THC), the active component of **cannabis**
- Methylamphetamine, also known as **speed, ice** and **crystal meth**
- Methylenedioxymethylamphetamine (MDMA), also known as **ecstasy**
- Benzoylecgonie, the major metabolite of **cocaine**
- Opiates, which can be found in **heroin, morphine** and **codeine**
- **Alcohol**

What are the permitted levels?

- The testable drugs will be measured against the target concentrations specified in table 5.1 of **Australian Standard 4760-2006**
- For alcohol, a concentration of 0.02 gm/dL and above of alcohol in 100 ml of blood (**BAC 0.02%**) is positive

On who, when and where will testing be conducted?

- Any person present in an area that **safety sensitive aviation activities** are undertaken can be asked to undergo a test in accordance with the regulations
- Testing will be conducted **365 days, 24/7**
- Testing will be where any safety sensitive aviation activities occur and **will not be limited** to metropolitan and major regional centres

How will the testing work?

- An **independent authorised collector** can ask for an oral fluid sample for drug testing and/or a breath sample for alcohol testing

Drug Testing

- All testing will be conducted with **privacy** a primary consideration
- For the purposes of drug testing, the donor will be asked to provide a measured **sample of oral fluid** on the device provided
- The screening for the presence of any of the target drugs takes approximately **five minutes**
- If the test is **negative** they will able to continue on with their duties
- If the test is **positive** they will be required to be observed while the sample is split and the specimens then sealed for security; both these samples will be sent to a laboratory for confirmatory analysis
- The donor will be then asked to **stand down** until a CASA **Medical Review Officer** authorises their return to duties
- When the results are confirmed, the donor will be contacted by a CASA MRO to verify the nature of the positive result

Alcohol Testing

- All testing will be conducted with **privacy** a primary consideration
- For the purposes of alcohol testing, the donor will be asked to provide a **measured breath sample**
- A positive or negative result will be known **at the time of the testing**
- If the test is **negative**, they will able to continue on with their duties
- If the test is **positive,** they will be required to wait with the authorised collector for 20 minutes before providing a second confirmatory sample
- If the **confirmatory test** is negative, a negative test result is recorded and the donor can continue on with their duties
- On the positive result being **verified,** the donor will be asked to stand down until authorised to return to their duties

Testing methodology

As the role of any AOD management plan is to promote safety in the workplace, the reality is that different approaches are appropriate for different contexts. The CASA mandated random testing is primarily an auditing/assessment tool of a much broader program covering safety sensitive activities within the aviation sector.

The programme as a whole is the joint responsibility of both CASA and industry including education/awareness, employee assistance programs, rehabilitation and return to work programs.

In the past decade there has been increasing interest and debate surrounding AOD testing in the workplace, including the using of traditional (urine) and non-traditional matrices (oral fluid, sweat and hair).

The testing for drugs in urine is recognised worldwide, but due to the detection in some cases of metabolites with long half-lives (namely 9-Delta-THC-COOH) it is used more as a risk management tool, enabling assistance and further education of individuals identified within this system. The presences of target substances in urine correlate very little if at all to acute impairment.

Oral fluid testing has been evolving rapidly in the last 3-4 years and has been adopted particularly in relation to individuals driving motor vehicles. In Australia, the Victorian Police in their first year of testing performed 13,176 tests with the intent to detect recent use, and by extrapolation acute impairment, at a time when the driver may be a higher safety risk to the community. As stated, oral fluid testing does not test for impairment per se; however, a number of pharmacokinetic studies have, on average, shown a reasonable correlation between oral fluid and blood concentrations for water soluble substances.

CASA's primary role and responsibilities have informed its philosophy in regards to the overall program, including an element of random testing. As the onus is on CASA to provide evidence that an aviation worker knowingly presented for duty, or was on duty, while under the influence, oral fluid is judged to be the preferred matrix.

Within industry however there is a greater ability to manage potential risk behaviour in a positive and constructive manner and like any safety innovative AOD programmes are one of many tools utilised. As the focus in the majority of AOD programmes is education, assistance and risk minimisation, the aim is based on identification rather than 'capture'. For this purpose, both urine and oral fluid would meet the intended criteria, with urine testing adding a further level of deterrence.

The role of the Medical Review Officer (MRO) in AOD testing

The role of the MRO is to be an impartial and independent gatekeeper for the integrity and accuracy of the drug testing process. The MRO's prime responsibility is to review and interpret lab confirmed 'positive' test results.

This involves review chain of custody documentation, direct contact with the employee or candidate for each positive test to determine any rational explanation for the positive result, and subsequently examination of alternate explanations for positive, adulterated, substituted or invalid results.

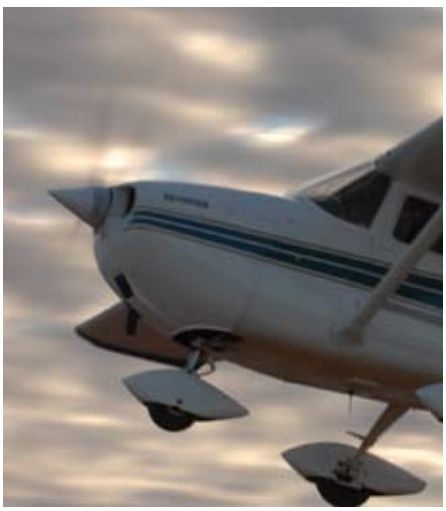
In the final analysis, the MRO must verify the test as negative, positive, or test cancelled. The MRO then liaises with the appropriate authority or designated employer representative with respect to the result of the test.

The requirements of an MRO are:

- must be a licensed medical doctor
- be knowledgeable of substance abuse disorders
- have specialist knowledge of and training in:
  - specimen collection procedures
  - analytical procedures
  - chain of custody
  - alternative explanations for positive analytical results
  - relevant policies and regulations

The MRO may have undertaken further study such as US and European certification and education programs (AAMRO, MROCC, EWDTS); there is no current Australian training, or regulation.

DAMP organisations will be required by the regulations to use an MRO for review of drug testing and CASA will use MRO's to review all CASA random drug test reports



Problematic use of AODs

Alcohol and other drug (AOD) use exists along a continuum ranging from non-problematic, low-risk use through to dependence. The majority of problems association with AOD use stem from risky or high risk use rather than the minority of users who experience dependence.

The vast majority of people who use AOD present to their GP in the first instance when problems arise. Risky AOD use can also confound a differential diagnosis and complicate treatment for general health problems (eg hypertension). There is ample scope for GPs to respond to these patients and with every likelihood of a successful outcome.

Early recognition of AOD related problems is important. It can enable intervention to occur before dependence or irreversible damage has developed, or before problems become more complex and difficult to treat. However, alcohol and drug (AOD) problems can be difficult to detect, especially in the early stages.

Indicators of AOD problems may include:

- domestic violence (actual or threatened)
- risks for children (e.g. neglect or intoxication-related harm)
- social isolation
- anxiety / depression
- stress management
- other drugs used to self-medicate

General practice and primary health care offer a variety of opportunities to enquire about AOD use. For example, in the context of:

- a new patient assessment – as part of initial information gathering
- management of chronic problems – alcohol for example, is a risk factor in cardiovascular disease, diabetes, depression
- management of acute problems, especially trauma, gastrointestinal disorders, anxiety / stress, psychological problems
- preoperative assessment
- pre-conception and antenatal care
- enhanced Primary Care Medicare Benefit Schedule items – health assessment, care plans and case conferences

Although AOD problems may be the primary presenting problem, they are more commonly detected when the patient presents for another issue.

Low key, generic questions that are useful include:

- 'Many people use alcohol or sometimes other drugs to relax, how about you?'
- 'Many of my patients drink alcohol, do you?'
- 'I'd like to ask a few questions about your general lifestyle.'
  - Tell me about your diet.
  - How much exercise do you get?
  - Do you smoke?
  - Drink alcohol?
  - Take other drugs?

If the patient answers 'yes' to any of these last questions, probe further and seek specific information about quantities and frequencies. Do not settle for vague responses such as 'I'm a social drinker.' Early recognition of AOD-related problems is more likely when the health professional:

- is aware that psychosocial problems occur before most physical problems
- is willing to follow up with detailed enquiry and appropriate investigations

Assessment helps the doctor and patient, working together, to link high-risk AOD use to:

- past life experiences and expectations
- lifestyle, social and occupational factors
- physical and psychological conditions
- motivations for reducing / ceasing AOD use

Assessment is essential for formulating an individually tailored and negotiated treatment plan.

Some specific drug-related questions to consider include:

- 'When did you start using XXX?'
- 'Have you stopped before and if so, for how long?'
- 'What led you back to using?'
- 'Have you had any treatment and what was the outcome?'
- 'What do you like about using drugs?'
- 'In what ways does drug use help you to cope?'
- 'What concerns you about your drug use?'

A comprehensive assessment can:

- bring some clarity (to both patient and doctor) about what may seem like a 'chaotic array of happenings'
- build rapport and instil a sense of direction
- indicate areas in need of urgent attention
- identify areas that will benefit from harm minimisation strategies
- provide a basis for treatment recommendations

The information above has been adapted from: 'Resource Kit for GP Trainers: Illicit Drug Issues' National Centre for Education and Training on Addiction Consortium, Flinders University (2004). Australian Govt Dept Health and Ageing.

DSM criteria for determining problematic use of substance:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the following, occurring at any time in the same 12 month period:

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect

(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for 'withdrawal' from the specific substances)

(b) the same (or a closely related substance is taken to relieve or avoid withdrawal symptoms

(3) the substance if often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from these effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:

with physiological dependence: evidence of tolerance or withdrawal (i.e. either item 1 or 2 is present)

without physiological dependence: no evidence of tolerance or withdrawal (i.e. neither item 1 or 2 is present)

Course specifier
Early full remission
Early partial remission
Sustained full remission
Sustained partial remission
On Agonis therapy
in a controlled environment

Criteria for substance withdrawal

A. The development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged.

B. The substance-specific syndrome causes clinically significant distress or impairments in social, occupational, or other important areas of functioning.

C. The symptoms are not due to a general medical condition and are not better account for by another mental disorder

Criteria for substance abuse

A. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the following, occurring at any time in the same 12 month period:

(1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving a motor vehicle or operating machinery when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

ICAO definition of Problematic use of Substance

Problematic use of substance or problematic substance use is the use of one or more psychoactive substances by aviation personnel in a way that:

a) Constitutes a direct hazard to the user or endangers the lives, health or welfare of other; and/or

b) Causes or worsens an occupational, social, mental, or physical problem or disorder.

AOD: Useful website resources

www.aodgp.gov.au/internet/aodgp/publishing.nsf/Content/home

This is the home page for *Alcohol and Other Drugs: a website for General Practitioners and Health Professionals*. The website is a companion to *Alcohol and Other Drugs: A Handbook for Health Professional and the Resource Kit for GP Trainers on Illicit Drug Issues*.

The suite of resources accessible through the website was produced by a consortium headed up by the National Centre for Education and Training on Addiction (NCETA) at Flinders University.

http://therightmix.gov.au/

or

http://therightmix.gov.au/professionals.asp

The Alcohol Management Project (AMP) was created to develop a response to alcohol and substance use disorders and related problems in the veteran community, as identified in DVA's mental health policy and the Vietnam Veterans Health Study. The project is being developed in the context of the National Alcohol Strategy.

The Alcohol Management Project is a partnership of ex-service and veteran community organisations and the Department of Veterans' Affairs that aims to promote a healthier approach to alcohol use by veterans and their families. The project also maintains active partnerships with a number of organisations outside DVA. including:

- Department of Health and Ageing
- Department of Defence
- Australian Centre for Posttraumatic Stress Disorder and Mental Health

The project has developed the Alcohol Screening and Brief Intervention (AS+BI) Manual for use by health providers and peer educators working with and treating veterans and their families, and has released Clinical Practice Guidelines for Alcohol Treatment in partnership with the Australian Centre for Posttraumatic Mental Health (ACPMH).

www.apsad.org.au/

The Australasian Professional Society on Alcohol and other Drugs (APSAD). APSAD is dedicated to raising awareness about the problems related to the use of alcohol and other drugs, and to promoting improved standards in clinical practice and in research into this and allied subjects.

www.adf.org.au/

The Australian Drug Foundation (ADF) is a major Australian non-government organisation, established in 1959. The ADF prevention agenda is delivered on a platform of harm minimisation, encompassing a continuum of comprehensive prevention strategies, from abstinence to the management of severe and chronic drug misuse.

The ADF website contains a comprehensive collection of good quality, reliable alcohol and other drug information, including education resources and policy guidelines.

www.turningpoint.org.au

Turning Point Alcohol and Drug Centre was established in 1994, and is regarded as a leading provider of services in the AOD sector. Turning Point also has a strong research agenda. Turning Point is formally affiliated with St Vincent's Hospital Melbourne and the University of Melbourne. Turning Point is part of the International Network of Drug Treatment and Rehabilitation Resource Centres for The United Nations Office of Drugs and Crime (UNODC) and is a member of the International Harm Reduction Association. The Centre is also a Registered Training Organisation and an accredited Higher Education Provider.

http://www.ndarc.med.unsw.edu.au

The National Drug and Alcohol Research Centre (NDARC), at the University of NSW, opened in 1987. It is funded by the Australian Government as part of the National Drug Strategy. NDARC's mission is to conduct high quality research and related activities that increases the effectiveness of Australian and International treatment and other intervention responses to alcohol and other drug related harm.

The National Drug and Alcohol Research Centre is not an information centre, and has a limited ability to provide drug information to the general public. However, due to great demand, the Centre has produced a series of fact sheets on a range of drugs and statistical data which may prove useful.

www.drugscope.org.uk/

DrugScope is the UK's leading independent centre of expertise on drugs, with the aim of informing policy development and reducing drug-related risk. The organisation provides quality drug information, promotes effective responses to drug taking, undertakes research at local, national and international levels, and advises on policy-making.

CERTIFICATION ISSUES

– Dr David Fitzgerald

Dr Dave's hints and tips for hassle-free certification

What CASA wants to know

The structure of aviation medical regulation in Australia means that the final decision maker about a certificate holder's fitness to fly is the 'delegate' of CASA – who is either Dr Sham or Fitzgerald.

The DAME is heavily relied upon by the staff at CASA in their assessment of the applicant's suitability for meeting the standards. On occasion, not enough detailed information is included in the medical to satisfy CASA's medical officers that a full assessment of an applicant's history/condition has been carried out.

The following is a list of info which would, for each condition, be considered necessary to include in the comments on the medical to satisfy CASA. These items may be of use also in asking specialists to provide details:

1. Asthma

On initial issue, any history of hospital admission or use of oral steroids, and current status.

2. Ischaemic heart disease

In addition to yearly stress testing, a clinical assessment by a cardiologist is required, particularly with respect to control of risk factors.

3. Kidney stones – history of

CASA will require evidence by either radiological investigations, or specialist letter, that the applicant is free of stones.

4. Diabetes Mellitus on sulphonylureas

As this class of medication is associated with hypoglycemia, applicant's recent BSL readings are required.

5. Psychiatric illness

The following items are useful: date of onset, symptoms, treatment, response to treatment, side effects, DSM IV diagnosis, history of hospital admission, psychosis, mania or suicidal ideation, current status and prognosis.

6. Cancers

Date of diagnosis, staging, grade of tumour, risk of and site of metastases.

7. History of illicit drug use

Recent drug screen.

8. Orthopaedic conditions

Assessment by DAME of effect of condition of operation of aircraft controls.

9. Head injuries

Date of injury, circumstances of injury, loss of consciousness, details of hospital admissions, scan results, ongoing sequelae.

If these items are included either in the DAME comments or in a specialist report, the delays in certification while CASA sources information will be significantly shortened.

A message from your friendly Assessors and Dame Liaison Officer

We would like to thank all of you for your continuous support and hard work. We have some suggestions that will make the process more efficient and reduce the delays in the certification process

Are you tired of all the letters we send you?

Sometimes, it is better to give than to receive. So if you ***give*** us all of the right information, you won't ***receive*** a letter of enquiry.

• The PULSE RATE is to be completed on the medical. Please don't write 'Look at the ECG' on the medical. If the pulse rate has not been completed – ***you will receive a letter***

• The blood pressure reading is to be noted on the medical, if not – ***you will receive a letter***

• The VISION section should be FULLY completed, including visual acuity both WITH and WITHOUT correction. If an ophthalmologist report is supplied and the medical page is not completed – ***you will receive a letter***

• Any medication, medical condition, hospitalisation or abnormalities marked 'yes', please comment in the comment section, or – ***you will receive a letter***

• If applicant has been referred to a specialist of any kind, e.g. stress ECG, please note in detail in the comment section or – ***you will receive a letter***

We understand that you can read your own hand writing; however that does not necessarily mean that *we* can, so please print clearly or – ***you will receive a letter*** (unless we can't read your address, either...)

• Please remember: a class 1/3 applicant who has turned 60 requires the coronary risk factor to be calculated YEARLY, and if more than 14 points, please supply a stress ECG or – ***you will receive a letter***

• Please remember: a class 1/3 applicant who has turned 60 requires a CASA designated ophthalmologic assessment every two years or – ***you will receive a letter***

• Please ensure the medical has been signed and the applicant has been identified or – ***you will receive a letter***

Lets all work together to save the letters

Some other tips

• A certificate that has condition 1 "To be revalidated by CASA only" should not be revalidated by the DAME.

• The cardio/ ECG section at the bottom of the last page of the application is to be completed by a qualified cardiologist only and not by a DAME.

• Please ensure that you have Original and Renewal paper-based medicals in stock even if you use the online system – as you never know when you may need one of them.

• Please do not hold on to a medical whilst waiting for reports to come in, as it delays the applicant's certification. A lot of the time the reports get sent straight to CASA.

• Please note that if you make comments in the comments section that require our attention, please mark the 'any concern' box on the medical, as this will create a delay and alert the assessor.

We quite often get calls from DAMEs asking, 'When is an Original required?'

An original application is required for:

1. Initial application for all classes; or

2. Upgrading from class 2; or

3. If the medical certification has expired for more than 5 years.

A special message for our DAO's

Please ensure to complete the colour vision section and ensure that the application has been signed.

Welcome!

We would like to take this opportunity to welcome all of our newly registered DAME's and DAO's.

We wish you all a very merry Christmas and a prosperous new year.

Your friendly Aviation Medicine Medical Assessors:

Rose Hardy

Monique Shand

Ellen Kille

Dawn Waters
Dawn is acting in the DAME LIAISON position, and is more than happy to answer any of your inquiries. Ph: 02 6217 1254
email: dame.liaison@casa.gov.au

And welcome to our newest assessor, **Leanne Bradbury** (below)