I.M.A.T.S.

INTERNATIONAL MILITARY AIRBORNE TRAINING SCHOOL

Anmeldung für
25.-27.09.2015

Ihr Foto

Bewerber Information				**Fallschirmsprung Qualifikation**	
Nachname:				*Springer* ☐	*Nichtspringer* ☐
				Static-line qualifiziert ☐	*Freifall qualifiziert* ☐
Vorname:				*Dauer des mil.Fallschirmsprung Trainings:*	
Adresse:				*Ort des Trainings:*	
Bundesland, Stadt, PLZ:				*Ort und Datum des letzten Sprungs:*	
Tel.Nr.:				*Fallschirm-System und Absprungmaschine des letzten Sprungs:*	
Email:				*Anzahl aller Sprünge:*	*Anzahl aller Freisprünge:*
Geburtsort und Datum:				*Einheit des mil. Fallschirmsprung Dienstes:*	
Alter:	*Größe:*	*Gewicht:*	*Blutgruppe:*	*Dienstnummer:*	
Name und Rang wie dieser auf dem Zertifikat erscheinen soll:				*Abzeichen Anfrage:*	
Zimmerwunsch				*Reisepassnummer:*	
Hotel ☐		*Bunkhouse* ☐			
				Land:	
				Ablaufdatum:	
Notfallkontakt *(optional)*					
Name:				*Tel.Nr.:*	
				Fam.Verhältnis:	

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Medical Certificate

I hereby declare that I am physically fit. I do not, and have not, suffered from any of the following conditions which I understand may lead to a dangerous situation with regard to myself or other persons during parachuting operations:

Epilepsy fits, severe head injury, recurrent blackouts or giddiness, disease of the brain or nervous system, high blood pressure, heart or lung disease, recurrent weakness or dislocation of any limb, diabetes, mental illness, drug or alcohol addiction. For jumps in Czech Republic this certificate fits the requirements of class 2.

I further declare that in the event of contracting or suspecting any of the above conditions, or receiving any incapacitating injury or confirmation of pregnancy, I will cease to parachute until I have obtained professional medical approval. I also declare that I will carry any medication relating to any known illness or condition on my person at all times and will inform others as to its location and use. I have read the notes overleaf.

Name: _____

Date Of Birth: _____

Height: _____

Weight: _____

Signature: _____

DOCTORS CERTIFICATE

I understand that the applicant wishes to parachute, I have read the notes above and overleaf, I certify that he/she is physically, medically and mentally fit to parachute. Glasses or contact lenses must/need not be worn.

Signature:

Date of Signature.....**Date of certificate expiry**.....

Doctors stamp

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