FIREARMS LICENSING APPROVAL BOARD
MEDICAL REPORT FOR APPLICANTS

Mr./Ms./Mrs._____

Of _____

has informed me that he/she is in the process of applying for:

☐ Firearm License ☐ The renewal of a Firearm License

I have personally examined the applicant and attest to the accuracy of the information provided below. In view of the enormous mental and physical responsibilities that will be placed on the applicant if the application is approved, I fully understand and accept that erroneous information knowingly provided or relevant information knowingly omitted will result in the Firearms Licensing Approval Board reserving the right to reject any future reports prepared by me.

MEDICAL/PHYSICAL EXAMINATION

Is the Applicant a ☐ Regular Patient ☐ Occasional Patient ☐ New Patient

Applicant's Eyesight ☐ Good ☐ Fair ☐ Poor
Comments if any _____

_____

Applicant's Hearing ☐ Good ☐ Fair ☐ Poor
Comments if any _____

_____

Applicant's Mobility ☐ Good ☐ Fair ☐ Poor
Comments if any _____

_____

Applicant's Blood Pressure ☐ Good ☐ Fair ☐ Poor
Comments if any _____

_____

Applicant's Motor Skills ☐ Good ☐ Fair ☐ Poor
Comments if any _____

_____

Are all applicant's limbs intact? ☐ Yes ☐ No

If **NO,** (please provide details): _____

Applicant's Height _____cm. Applicant's Weight _____kg

Process

1. All costs incurred will be borne by the applicant.
2. Applicant visits a registered Medical Practitioner with FALAB Medical Form.
3. Medical Practitioner conducts examination of the applicant.
4. Medical Practitioner completes FALAB Medical Form.
5. Applicant retains Form and submits it along with Firearm Licence Application and the other supporting documents.

Previous Hospitalisation:	☐ Yes	☐ No	
Hospital and Year_____			
Applicant's General ***MENTAL*** Health	☐ Good	☐ Fair	☐ Poor
Comments if any _____			
Suicidal Thoughts	☐ Present	☐ Past	☐ Never
Suicidal Attempt	☐ Yes	☐ No	☐ Never
Depression	☐ Present	☐ Past	☐ Never
Suicide in Family	☐ Yes	☐ No	☐ If **YES**, provide details
Homicide in Family	☐ Yes	☐ No	☐ If **YES**, provide details
Drug Use (e.g Cocaine, Marijuana)	☐ Yes	☐ No	
Alcohol Use	☐ Abuse	☐ Occasional User	☐ Does Not Use
Is the Applicant considered to be Impulsive	☐ Yes	☐ No	
Is the Applicant prone to fainting spells or dizziness?	☐ Yes	☐ No	
Is the Applicant suffering from epilepsy?	☐ Yes	☐ No	
Does the Applicant suffer from any debilitating pains or cramps?	☐ Yes	☐ No	

Have you prescribed to the applicant any medication, which may negatively impact on his/her ability to protect and use a firearm? ☐ Yes ☐ No

If **YES**, state whether the applicant will be required to take these prescription drugs on a long term or permanent basis and provide details _____

Is there any other medical condition that may negatively impact on the applicant's ability to protect and use a firearm competently? _____

DOCTOR'S RECOMMENDATION

I _____examined _____
and in my professional opinion, I am of the view that he/she is fit and suitable to be a firearm holder.

DETAILS OF MEDICAL FACILITY AND MEDICAL PRACTITIONER

Name of Medical Facility	
Address of Medical Facility	
Telephone No. of Medical Facility	
Date of Examination	
Name of Medical Practitioner (Print)	
Registration No.	
Signature and Stamp of Medical Practitioner	