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|  | | | Sex□ | F□ | M□ | Age: | Destination: | | | | Contact Phone: | | | | | |  | |
| Medical History: | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | |  | | | | | | | |  | |
| Final Diagnosis: | | | | | | | | | Date of Diagnosis: | | | | | | | |  | |
| Contagious and Communicable Disease? | | | | | No□ | Yes□ | Remarks: | | | | | | | | | |  | |
| Is the patient's condonation likely to be source of discomfort to other passengers  (color appearance, conduct) | | | | | | | | | No□ | | Yes□ | | | Remarks: | | |  | |
| Transferring of the airplane: | | | | Regular□ | | Elevator□ | | | Wheelchair□ | | | | | Stretcher□ | | |  | |
| Position of the Patient Onboard: | | | | Regular  Seat□ | | Extra Seat□ | | | Stretcher□ | | | | | | | |  | |
| Does the patient Need Special Care Onboard? | | | | No□ | Yes□ | Normal  Attendant□ | | | Control of  Vital Sign□ | | | | | Medication□ | | |  | |
| Oxygen Demand: | | | | No□ | Yes ( Rate of Flow Lit/Min)□ | | | | Continuous□ | | | | | On Demand□ | | |  | |
| Does the patient Need Ambulance on Destination? | | | | No□ | | Yes (Coordination for Ambulance should be done by the Patient)□ | | | | | | | | | | |  | |
| Does the patient Need Hospitalization on Destination? | | | | No□ | | Yes (Coordination for Ambulance should be done by the Patient)□ | | | | | | | | | | |  | |
| Suggestions ( Diet, Medication, …): | | | | | | | | | | | | | | | | |  | |
| It is Attended Physician of the Patient  Accept the responsibility of the above mentioned information. | | | | | | | | | | | | | | | | |  | |
| Contact phone of the Physician:    Signature of attending Physician: | | | | | | | | | | | | | | | | |  | |
| Considerations of the airline trustee physician for carriage of the patient:  Sig. of airline trustee physician:  Date: | | | | | | | | | | | | | | | | |  | |
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Passenger's DECLARATION and patient participant

This is (patient/ patient participant)………………………..while requesting for any and all services needed for the carriage of the patient by air to his/her destination hereby authorize doctor…………………..(as a trusted and/or designated physician from the ATA Airlines medical center) to give his/her medical advice about the patient s general health condition to the extent required to determine patient s fitness and condition for an air travel from the medical point of view and if necessary to release / or disclose any such medical information to any other airline medical center as well as any relevant sources those who are legally and/ or medically allowed to have access to such information without any liability whatsoever which may arise out of any such disclosure.

I fully understand and confirm that. When the patient has medically been found fit for the air travel the journey will be made in accordance with the airline's general condition of the carriage and according to its applicable tariffs and thus the air carrier/ airline shall not assume any further liability other than those laid down in its general conditions of the carrier as well as in its tariffs. I personally at my own full risk confirm that I accept any and all consequences what's over may the air traveling cause to the patient s health condition and as a result shall fully indemnify the air carrier its servants employees and agents from and against any and all liabilities arising there from and also agree and confirm to reimburse to the carrier upon its demand any and all the particular costs and expenses incurred and confirm to reimburse to the carrier in relation to the patient s carriage by air.

Patient/ patient participants name & surname

Date & signature

-This from is valid for 48 hours after clearance of the airline trustee physician.

-Cabin crew are trained only in FIRST AID and are NOT PERMITTED to administer any injection or to give medication.