Medical Information Form (MEDIF)

FORM A Information Sheet For Passengers Requiring Special Assistance to be filled by the passenger

A	Passenger Name/Initials Title				Nationality	Age/Sex	Contact No.
B	Date	Flight No.	From	To	Class	Reservation Status	Booking Reference (PNR)
C	Nature of Incapacitation / Illness						
D	Intended Escort Details						
	Name						
	Language Spoken						
	Escort: Doctor	Medical Team			Nurse	Family or non-medical	
	PNR of the Escort				Note:		
E	Are there any special in-flight arrangements required? Special meals, special seating, extra seat(s), wheelchairs, equipment provision of special equipment for oxygen etc.						
F	Ambulance Arrangement: Departure Port Yes No Transit Port Yes No Destination Port Yes No				Has hospital admission been confirmed at destination port?		
					Hospital Details: (full name, address and telephone No.)		
	*Note: All ambulance and hospital arrangements must be arranged by the treating doctor / hospital or family members.						
G	Additional Passenger Information						

H	Do you have a valid FREMEC card? Yes No				
	If yes, add below FREMEC data to your reservation requests.				
	Number	Issued By	Valid Until	Incapacitation	

In order to enable Alliance Air to confirm my fitness to fly for my booked flights, I hereby consent to disclose the necessary information to Alliance Air solely for the purpose of determining my fitness to fly and to fulfil my special assistance requirements. I reserve the right to revoke my consent to Alliance Air to process my medical information at any time, but recognize that this may result in my being deemed not fit to fly and being therefore denied carriage on my booked flights. If the flight was already booked, there might be cancellation fees. I agree to notify Alliance Air if there is any change in the status of my medical condition before my flight to avoid being refused for travel.
Yes, I have read and understood the above statement and hereby consent to the processing of my personal data/the personal data of the minor or person whose legal guardian I am.

Passenger or Guardian's signature Date_____

Medical Information Form (MEDIF)

FORM B Information Sheet For Passenger Requiring Medical Clearance

To be completed by the PHYSICIAN ATTENDING the incapacitated passenger.

Patient's Family Name/Initials:	Age	Sex F M

Wheelchair Needed? Yes No

WCHR (Can climb steps/walk cabin) WCHS (Unable to climb steps/can walk cabin) WCHC (Immobile)

ATTENDING PHYSICIAN: (Name & Address)

A	Name of Hospital or clinic and specialty					
B	MEDICAL DATA: DIAGNOSIS in detail:					Telephone (Business) Mobile: Date of first symptoms: Date of diagnosis: Date of operation: Expected date of delivery:
	Vital Signs	BP	HB		LMP	HT WT
C	PROGNOSIS for the flight: GOOD (No problems anticipated) GUARDED (Potential problems) POOR (Problems likely)					Narrative: (e.g. late stage disease, unstable, complicated/uncomplicated pregnancy)
D	Contagious and communicable disease? Yes No Specify:					
E	Would the physical and/or mental condition of the patient be likely to cause distress or discomfort to other passengers? Yes No Specify:					
F	Can patient use normal aircraft seat with seat belt placed in the upright position when so required? Yes No Specify:					

G	Can patient take care of his/her needs onboard unassisted? (Including meals, visit to toilet,etc.) Meals Yes No Visit to toilet Yes No Specify:
H	If to be ESCORTED, by whom? Doctor Nurse Non-medical Passenger traveling alone Other(please specify): If not, state travel companion or proposed escort by you
I	Does the patient need "OXYGEN" equipment in flight? (If YES, please state rate of flow): Continuous Yes No Litres Per Minute (Between 2 to 8 LPM) Specify:
J	Does the patient need any MEDICATION, other than self-administered, and/or the use of special apparatus such as respirator, incubator, ventilator, nebulizer, etc.?*(Note: all battery operated equipment on board must be dry or non-spillable, otherwise specify:) A) On the ground while at the airport(s) Yes No Specify: B) On board the aircraft Yes No Specify:
K	Does the patient need HOSPITALISATION, (If YES, indicate arrangement made, or if none were made, indicate "No action taken") (Note: The attending physician and/or Patient is responsible for all arrangements). A) During connecting points Yes No Specify: B) Upon arrival at destination Yes No Specify:
L	Additional clinical information A) Anemia Yes No If yes, give recent result in grams of hemoglobin: B) Psychiatric and seizure disorder Yes No If yes, see part 2 C) Cardiac condition Yes No If yes, see part 2 D) Normal bladder control Yes No If no, give mode of control: E) Normal bowel control Yes No If no, give mode of control: F) Respiratory condition Yes No If yes, see part 2
	Please ensure that all above information is accurate. Once approved, no last minute changes will be entertained. Alliance Air must be informed of any change in patient's status or requirement at least 48 hours prior to departure.
M	I have read, understood and hereby agree to the conditions of the MEDIF formAttending Physician's Signature & Stamp Place Date

	Alliance Air Medical Examiner Approved Rejected Signature and stamp	Remarks

MEDICAL CERTIFICATE FOR EXPECTANT MOTHER

Patient name: _____

Age: _____

EDD(Estimated Date of Delivery): _____ (DD/MM/YY)

Proposed dates of air travel: 1. Outbound _____ (DD/MM/YY)
2. Inbound _____ (DD/MM/YY)

Additional Remarks if any:

In my opinion this woman has:

A complicated/ uncomplicated single pregnancy of _____weeks gestation

Or

A multiple complicated/ uncomplicated pregnancy of _____weeks gestation.

I consider the passenger "Fit to Travel" for the time covering the entire journey with Alliance Air.

Yours sincerely,

Doctor's Name:

Signature of Doctor:

Date:

Doctor's stamp:

Contact of Doctor: