Travel Clearance Form with Alliance Airlines

Passenger Details

Surname_____ Christian name_____

Age_____

Address_____

_____ Telephone No. ( )_____

Proposed Itinerary (First two sectors only required)

Booking Ref. Number _____

Airline | _| _| _| _| _| Flight No. | _| _| _| _| Class | _| Date | _| _| _| _| _| _| From _____ to _____

Airline | _| _| _| _| _| Flight No. | _| _| _| _| Class | _| Date | _| _| _| _| _| _| From _____ to _____

This section is to be completed by the treating doctor. Please complete only after careful consideration to the effects of air travel on the passenger.

Diagnosis *(if necessary, provide details on a separate sheet)*

Travel Arrangements

Is a wheelchair required to the aircraft door or seat?	**To the door**	**To the seat**	**NO**
Is an escort required to assist boarding the aircraft, eating, medication or toileting?		**YES**	**NO**
Is a medically trained escort necessary?		**YES**	**NO**
Name of escort if required			
Qualifications of escort (if any)			
Is the passenger travelling from hospital?		**YES**	**NO**
If an ambulance is required, have all the necessary arrangements been made? ***Clearance for travel cannot be given until ambulance booking is confirmed***.		**YES**	**NO**

Is there any of the following equipment required?

Stretcher Humidicrib Electrical Other

If yes, please provide details.

Is supplemental oxygen required in-flight?	**YES**	**NO**
If supplemental oxygen is required, what flow rate is required?	2L/m	4L/m
	Continuous	Intermittent

Other relevant information

NOTE*: Except for in-flight emergencies, Alliance Airlines does not offer in-flight medical treatment for passengers. Should a passenger require personal in-flight oxygen, they will need to make their own arrangements for the supply of oxygen bottle(s) prior to the proposed flight.*

I certify that the above named passenger is fit to travel on the proposed flights. I further certify that this person does not have any contagious disease that could *directly* place another passenger or crew member at risk, or that would contravene relevant Quarantine or Public Health Department regulations.

Doctors Name_____

Qualifications_____

Signature_____

Date_____

Address_____

Telephone Number_____