MEDIF – MEDICAL INFORMATION FORM FOR AIR TRAVEL
HANDLING INFORMATION – PART 1

Part 1

Answer all questions. Put a cross (x) in 'Yes' or 'No' boxes. Use **block letters** or **typewriter** when completing this form

To be completed by Sales Office / Agent

A **NAME / INITIALS / TITLE :**

B **Proposed Itinerary** (airline(s), flight number(s), class(es), date(s), segment(s), reservation status of continuous air journey)

FLIGHT	DATE	FROM	TO

PNR NUMBER

Transfer from one flight to another often requires longer connecting time

C **Nature of Incapacitation**

Medical clearance required?
☐ No
☐ Yes

D **Is stretcher needed onboard?** (all stretcher cases must be escorted) ☐ No ☐ Yes

Request rate if unknown

E **Intended escort** (Name, sex, age, professional qualification, segments, if different from passenger). If untrained, state **'Travel Companion'**

For blind and/or deaf state if escorted by trained dog

F **Wheel chair need?** ☐ No ☐ Yes

Own wheelchair?	Collapsible?	Power driven?	Battery type (spillable?)
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Wheelchair category Categories are WCHR, WCHS, WCHC

Wheelchairs with spillable batteries are restricted articles and are permitted on passenger aircraft only under certain conditions, which can be obtained from the airlines(s). In addition, certain countries may impose specific restrictions.

G **Ambulance needed?** ☐ No ☐ Yes

To be arranged by **airline**
☐ No ☐ Yes

Specify ambulance company contact

Specify destination address

Request rate(s) if unknown

H **Other ground arrangements needed** ☐ No ☐ Yes

If Yes, specify below and indicate for each item, (a) the arranging airline or other organization, (b) at whose expense, and (c) contact addresses/phones where appropriate, or whenever specific persons are designated to meet/assist the passenger.

1	Arrangements for delivery at airport of **departure**	☐ No	☐ Yes	specify
2	Arrangements for assistance at **connecting points**	☐ No	☐ Yes	specify
3	Arrangement for meeting at airport of **arrival**	☐ No	☐ Yes	specify
4	Other requirements or relevant information	☐ No	☐ Yes	specify

K **Special In-Flight arrangements needed,** such as special meals, special seating, leg rest, extra seat(s), special equipment, etc. ☐ No ☐ Yes

If yes, describe and indicate for each item, (a) **segment(s)** on which required, (b) airline **arranged** or arranging third party, and (c) at whose expense. Provision of **special equipment** such as oxygen etc. always requires completion of **Part 2** overleaf.

(See "Note (*) at the end of **Part 2** overleaf

L **Does passenger hold a 'Frequent traveller's medical card' (FREMEC) valid for this trip** ☐ No ☐ Yes

If yes, add below FREMEC data to your reservation requests.
If no, (or if additional data needed by carrying airline(s), have physician in attendance complete **Part 2** overleaf.

(FREMEC No.)	(ISSUED by)	(VALID UNTIL)	(sex)	(age)	(INCAPACITATION)

(LIMITATIONS)

Passenger's declaration

I hereby authorize _____
(name of nominated physician)
to provide the airlines with the information required by those airlines' medical department for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fee in connection therewith.
I take note that, if accepted for carriage, my journey will be subject to the general conditions of carriage/tariffs of the carrier(s) concerned and that the carrier(s) do not assume any special liability exceeding those conditions/tariffs.
I am prepared, at m own risk, to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from any liability for such consequences.
I agree to reimburse the carrier(s) upon demand for any special expenditures or costs in connection with my carriage.
(Where needed, to be read by/to the passenger, dated and signed by him/her, or on his/her behalf.

Place:	Date:	Passenger's Signature

(for official use only)	**MEDIF - MEDICAL INFORMATION FORM – PART 2 CONFIDENTIAL**	Part 2
This form must be returned to: (Carrier's Designated Office)	This form is intended to provide **confidentia**l information to enable the airlines' **medical** department to assess the fitness of the passenger to travel as indicated in **Part 1** overleaf. If the passenger is acceptable, this information will permit the issuance of the necessary directives designed to provide for the passenger's welfare and comfort. The **Physician attending** the incapacitated passenger is requested to **answer all questions.** (Enter a cross (x) in the appropriate 'Yes' or 'No' boxes, and/or give precise concise answers). C**ompletion of the form in block letters or by typewriter will be appreciated.**	To be completed by **attending physician**

Airlines' ref code **MEDA 01**	**Patient's name, initial(s):**	Sex	Age
MEDA 02	**Attending physician** Name and address		
	Telephone contact	Business:	Home:
MEDA 03	**Medical data:** Diagnosis in details (including vital signs)		
	Day/month/year of first symptoms:		Date of diagnosis:
MEDA 04	**Prognosis** for the trip		
MEDA 05	Contagious **and** communicable disease?	☐ No ☐ Yes Specify	
MEDA 06	Is the patient's condition likely to be a source of discomfort to other passengers? (odor, appearance, conduct)	☐ No ☐ Yes Specify	
MEDA 07	Can patient use normal aircraft seat with seatback placed in the **upright** position when so required?	☐ Yes ☐ No	
MEDA 08	Can patient take care of his own needs onboard **unassisted*** (including means, visit to toilet, etc)?	☐ Yes ☐ No If Not, type of help needed	
MEDA 09	If to be escorted, is the arrangement proposed in **Part 1/E** overleaf satisfactory for your?	☐ Yes ☐ No If Not, type of Escort proposed by you	
MEDA 10	Does patient need **oxygen****, equipment in flight? (If yes, state rate of flow)	☐ No ☐ Yes Litres per minute Continuous ☐ Yes ☐ No	
MEDA 11	Does patient need any medication", other than self-administered, and/or the use of special apparatus such as respirator, incubator, etc.**	(a) on the **ground** while at the airport(s) ☐ No ☐ Yes Specify	
MEDA 12		(b) on board the **aircraft** ☐ No ☐ Yes Specify	
MEDA 13	Does patient need hospitalization? (if yes, indicate arrangements made or, if none were made indicated 'No action taken')	(a) during long layover or nightstop at **connecting** points en route ☐ No ☐ Yes **Action**	
MEDA 14		(b) upon arrival at destination ☐ No ☐ Yes **Action**	
MEDA 15	Other remarks or information in the interest on your patient's smooth and comfortable transportation.	☐ Specify if any**	
MEDA 16	Other arrangements made by the attending physician.		

Note(*):	Cabin attendants are not authorized to give special assistance to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in **First Aid** and are **not permitted** to administer any injection, or to give medication.	**Important:**	**Fees if any, relevant to the provision of the above information and for carrier – provided special equipment (**) are to be paid by the passenger concerned.**

Date:	Place:	Attending Physician's Signature