



M E D I F
STANDARD MEDICAL INFORMATION FORM FOR AIR TRAVEL

Answers All questions, Put a cross (x) in "YES or NO"
Use BLOCK LETTERS or TYPE WRITER when completing this form

PART 1 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)	Transfer from one flight to another after requires LONGER connecting time	

C NATURE OF INCAPACITATION		MEDICAL CLEARANCE REQUIRED No <input type="checkbox"/> Yes <input type="checkbox"/>
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D IS STRETCHER NEEDED ON BOARD? (all stretcher cases MUST be escorted)	<input type="checkbox"/>	<input type="checkbox"/>	Request care if unknown
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E INTENDED ESCORT (Name ,sex age, professional, qualification, segments if different from passenger if untrained state TRAVEL COMPANION)		For blind and/ or deaf, state escorted by trained-dog
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F WHEEL CHAIR NEEDED? Categories are WCHR WCHS WCHC	No <input type="checkbox"/> Yes <input type="checkbox"/>	OWN Wheelchair Yes <input type="checkbox"/> No <input type="checkbox"/>	Collapsible No <input type="checkbox"/> Yes <input type="checkbox"/>	Power Driver? No <input type="checkbox"/> Yes <input type="checkbox"/>	Battery Type (Spillable) No <input type="checkbox"/> Yes <input type="checkbox"/>	Wheelchairs with applicable batteries are "restriction articles" and are permitted on passengers aircraft only under certain conditions which can be obtained from the airlines(s). In addition certain countries may impose specific restriction
Wheelchair Category	<input type="text"/>					

G AMBULANCE NEEDED?	No <input type="checkbox"/> Yes <input type="checkbox"/>	To be arranged by AIRLINE No <input type="checkbox"/> → Specify Ambul Company contract Yes <input type="checkbox"/> → Specify Ambul Company contract	<input type="text"/> <input type="text"/> <input type="text"/>	Request rate(s) if unknown
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H OTHER GROUND ARRANGEMENTS NEEDED	No <input type="checkbox"/> Yes <input type="checkbox"/>		
1 Arrangement for delivery at airport of DEPARTURE	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify		<input type="text"/> <input type="text"/>
2 Arrangement for assistance at CONNECTING POINTS	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify		<input type="text"/> <input type="text"/>
3 Arrangement for meeting at airport of ARRIVALS	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify		<input type="text"/> <input type="text"/>
4 Other requirements or relevant information	No <input type="checkbox"/> Yes <input type="checkbox"/> Specify		<input type="text"/> <input type="text"/>

K SPECIAL IN-FLIGHT ARRANGEMENTS NEEDED such as special meals, special seating leg rest extra seat(s), special equipment, etc.	No <input type="checkbox"/> Yes <input type="checkbox"/>	If Yes DESCRIBE and indicate for each items(s) 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 require completion of PART 2 overleaf	<input type="text"/> <input type="text"/> <input type="text"/>
(See Note at the end of PART 2 overleaf)			

L DOES PASSENGER HOLD AFREQUENT TRAVELLERS MEDICAL CARD VALID FOR THIS TRIP(PREMEC)	No <input type="checkbox"/>	No <input type="checkbox"/>	if yes and below FREMEC date to your reservation requests. If no (or additional data needed by carrying airline(s) have physician in airline(s) have physician in attendance complete PART 2 hereof
EREMEC <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(EREMEC Number)	(Issued by)	(Valid until)	(Sex) (Age) Incapacitation)
(Incapacitation cont.)	Incapacitation)		

PASSENGER'S DECLARATION "HEREBY AUTHORIZE"

(Name of nominated physician)

To provide the airline with the information required by those airlines medical departments for the purpose or determining my illness for carriage by air and in carriage by air in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such physician's fees in connection therewith

I take note that if accepted for carriage, my journey will be subject to the general condition of carriage / amie of the carriage concerned and that the carrier does not assume any special liability exceeding those conditions/tariffs

I am prepared at my own risk to bear any consequences which carriage by air may have for my state of health and release the carrier, its employee is, servants and agents from any liability for such consequences

I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage (Where needed to be ready by/to the passenger dared and signed by him/her or on his/her behalf)

Place	Passenger's Signature
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Resolution 401
Recommended Practice 1401 - Attachment "B"

(Text may be modified by the airline issuing the MEDIF, to comply with local law)

PART 2	MEDIF MEDICAL INFORMATION SHEET	(for Official Use only)
To be completed by ATTENDING PHYSICIAN	<p>This form is intended to provide CONFIDENTIAL information to enable the airline MEDICAL Departments to access the fitness of the passenger to travel as indicated in PART 1 hereof. If the passenger is acceptable this information will permit the issuance of the necessary directives consigned to provide for the passenger's welfare and comfort</p> <p>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) COMPLETING OF THE FORM BLOCK LETTERS OR BY TYPEWRITER WILL BE APPRECIATED</p>	
	The form must be returned to <div style="border: 1px solid black; height: 40px; width: 100%;"></div> (Carrier's Designated Office)	
Airlines Ref: Code MEDA01	PATIENTS NAME INITIAL (S), SEX, AGE	
MEDA02	ATTENDING PHYSICIAN Name & Address	
	Telephone Contact Business Home	
MEDA03	MEDICAL DATA -DIAGNOSIS in details (including vital signs) _____ - Day/month, year of fist symptoms Date of diagnosis	
MEDA04	-PROGNOSIS for the trip	
MEDA05	- Contagious AND communicable disease? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify	
MEDA06	- Is patient in any way OFFENSIVE to other passengers? (Smeil appearance conduct) No <input type="checkbox"/> Yes <input type="checkbox"/> Specify	
MEDA07	- Can patient use normal aircraft seat with seatback placed in the UPRIGHT position when so required> No <input type="checkbox"/> Yes <input type="checkbox"/>	
MEDA08	- Can patient take care of his own needs on board UNASSISTED* (including meals visit to toilet etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/> _____	
MEDA09	-If to be ESCORTED is the arrangement proposed in PART 1 hereof satisfactory for you? Yes <input type="checkbox"/> No <input type="checkbox"/> If no type of escort proposed by YOU	
MEDA10	- Does patient need OXYGEN equipment on flight? (if yes state of flow satisfactory for you?) No <input type="checkbox"/> Yes <input type="checkbox"/> Litres Per Minute <input type="text"/> Continuous? <input type="checkbox"/>	
MEDA11	(a) on the GROUP while at the airport(s) - Does patient need any MEDICATION other than self administered and/or No <input type="checkbox"/> Yes <input type="checkbox"/> Specify _____	
MEDA12	(b) on board of the AIRCRAFT - The use of special apparatus such as respirator, incubator etc.? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify _____	
MEDA13	- Does patient need HOSPITALISATION? (If yes indicate arrangements made or if none were made, indicate "NO ACTION TAKEN") (a) during long layover or nights stop at CONNECTING POINT en route No <input type="checkbox"/> Yes <input type="checkbox"/> Action _____	
MEDA14	(b) upon arrival at DESTINATION No <input type="checkbox"/> Yes <input type="checkbox"/> Action _____	
MEDA15	- Other remarks or information in the interest of your patient's smooth and comfortable transportation <input type="text"/> Specify if any** _____	
MEDA16	- Other arrangements made by the attending physician	
NOTE(*) : Cabin attendants are NOT authorised to give special assistance to particular passengers, for the detriment of their service to other passengers - Additionally, they are trained only in FIRST AID and NOT PERMITTED to administer any in-jec-tion, 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 & Stamp