INDEMNITY: EXPECTANT MOTHERS

Please complete the form below in block letters:

Name of Passenger: Age:

Address: Contact Number:

Pregnancy Age: Months: _ _____ Weeks: _____ Days: _____

TO BE COMPLETED BY EXPECTANT MOTHER

I, the undersigned, hereby state that as of the date hereof, the age of my pregnancy is as set out above and does not exceed 34 weeks hereinafter referred as "*expectant mother/ Passenger*. I do not suffer from any abnormality connected with my current pregnancy. I hereby take full responsibility for any error or misrepresentation contained above, whether intentional or otherwise.

I hereby indemnify Precision Air Plc and its subsidiary companies (if any), staff members and agents from any liability arising out of any injury, aggravation, deterioration in health suffered either by myself or by my unborn child. I understand and acknowledge fully that:

1. No mother whose pregnancy exceeds 34 weeks on the date of travel is allowed to travel on a Precision Air flight; and that

2. Any mother whose pregnancy exceeds 24 weeks is required to submit a Medical Certificate filled within confirming her fitness to travel on a Precision Air flight.

3. Notwithstanding the aforementioned provisions of this indemnity Agreement, Upon knowledge, Precision Air reserves the right to deny boarding/offload any expectant mother who does not meet the requirements on the date of travelling (on originating, transit or return flight) irrespective of the date of purchasing the ticket, consulting medical practitioners and/or any error(s) that may have occurred at any stage

4. I am conversant with a detailed expectant mother policy as made available on www.precisionairtz.com and Precision Air offices.

I understand that Precision Air does not guarantee availability of medical personnel on its flights to attend to me or my unborn child and consent to the risks that may be associated therewith.

I warrant that I have read and understood the above and that by virtue of that understanding; I voluntarily agree to be bound thereto upon appending my signature below.

SIGNED AT ____ ____ ____ ON THIS ____ __ DAY OF _ ____ ____ ____ ____

Signature of Passenger

Precision Air
You are why we fly

PART 1
To be completed by SALES OFFICE/AGENT

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

A **NAME / INITIALS/TITLE**

B **PROPOSED ITINERARY**
(airline(s), flight number(s), class(es), date(s), segment(s) reservation status of continuos air journey

Transfer from one flight to another after requires LONGER connecting time

C **NATURE OF INCAPACITATION**

MEDICAL CLEARANCE REQUIRED No ☐ Yes ☐

D **IS STRETCHER NEEDED ON BOARD?**
(all stretcher cases MUST be escorted) ☐ ☐

Request care 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 escorted by trained-dog

F **WHEEL CHAIR NEEDED?**
Categories are **WCHR WCHS WCHC**

No ☐ Yes ☐
Wheelchair Category ☐

OWN Wheelchair	Collapsible	Power Driver?	Battery Type (Spillable)
Yes ☐	No ☐	No ☐	No ☐
No ☐	Yes ☐	Yes ☐	Yes ☐

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

G **AMBULANCE NEEDED?**

To be arranged by AIRLINE
No ☐ Yes ☐
No ☐ → Specify Ambul Company contract
Yes ☐ → Specify Ambul Company contract

Request rate(s) if unknown

H **OTHER GROUND ARRANGEMENTS NEEDED**
No ☐ Yes ☐

1 Arrangment for delivery at airport of DEPARTURE
No ☐ Yes ☐ Specify

2 Arrangment for assistance at CONNECTING POINTS
No ☐ Yes ☐ Specify

3 Arrangment for meeting at airport of ARRIVALS
No ☐ Yes ☐ Specify

4 Other requirements or relevant information
No ☐ Yes ☐ Specify

K **SPECIAL IN-FLIGHT ARRANGMENTS NEEDED** such as special meals, special seating leg rest extra seat(s), special equipment, etc.
(See Note at the end of PART 2 overleaf)

No ☐ Yes ☐

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

L **DOES PASSENGER HOLD AFREQUENT TRAVELLERS MEDICAL CARD VALID FOR THIS TRIP(PREMEC)**

No ☐ No ☐

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 ☐ ☐
(EREMEC Number) (Issued by)
(Incapacitation cont.) ☐

(Valid until) ☐ (Sex) ☐ (Age) ☐ Incapacitation) ☐
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 corriage, my joumey will be subject to the general condition of carriage / amie of the carriage concemed and that the carrier does not assume any special liability exceeding those conditions/tarrifs

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

Resolution 401
Recommended Practixe 1401 - Attachment "B"

Precision Air
You are why we fly

(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	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 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 concice answers) COMPLETING OF THE FORM BLOCK LETTERS OR BY TYPEWRITER WILL BE APPRECIATED	**The form must be returned to** **(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 ☐ Yes ☐ Specify
MEDA06	- Is patient in any way OFFENSIVE to other passengers? (Smeii appearance conduct)	No ☐ Yes ☐ Specify
MEDA07	- Can patient use normal aircraft seat with seatback placed in the UPRIGHT position when so required>	No ☐ Yes ☐
MEDA08	- Can patient take care of his own needs on board UNASSISTED* (including meals visit to toilet etc.)?	Yes ☐ No ☐
MEDA09	-If to be ESCORTED is the arrangement proposed in PART 1 hereof satisfactory for you?	Yes ☐ No ☐ 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 ☐ Yes ☐ Litres Par Minute ☐ Continuous? ☐ ☐
MEDA11	- Does patient need any MEDICATION other than self administered and/or	(a) on the GROUP while at the airport(s) No ☐ Yes ☐ Specify
MEDA12	- The use of special apparatus such as respirator, incubator etc.?	(b) on board of the AIRCRAFT No ☐ Yes ☐ 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 ☐ Yes ☐ Action
MEDA14		(b) upon arrival at DESTINATION No ☐ Yes ☐ Action
MEDA15	- Other remarks or information in the interest of your patient's smooth and comfortable transportation ☐	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-jection, 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**

APPENDIX "A" MEDIF FORM
Resolution 401
Recommended Pradice 1401 - Attachment "B"