طيران الخليج
GULF AIR

APPLICATION FOR THE CARRIAGE OF MEDICAL PASSENGER

PASSENGER/FLIGHT DETAILS

1. PASSENGER'S NAME……FAMILY NAME/OTHER NAME…….
   PERMANENT ADDRESS……TEL: ……
2. FLIGHT REQUESTED……..DATE……FROM……TO……..
3. I,……HEREBY INDEMNIFY AND HOLD GULF AIR HARMLESS FROM AND AGAINST ANY LIABILITY ARISING OUT OF ANY BODY INJURY AND/OR DEATH, DAMAGE OR LOSS I MAY SUFFER AND FROM AND AGAINST ANY OTHER DAMAGE, PAYMENTS, OF ACCEPTING ME FOR CARRIAGE ON ITS FLIGHT, AND I DO HEREBY UNDERTAKE TO REPAY GULFAIR THE SAME DAMAGES PAYMENTS, EXPENSES, FEES AND COSTS.
   I ALSO UNDERSTAND AND AGREE THAT ANY SUCH PAYMENTS, EXPENSES, FEES AND COSTS MADE OR INCURRED BY GULF AIR SHALL BE SOLELY FOR MY WELFARE AND WILL BE WITHOUT PREJUDICE AND ENTIRELY WITHOUT ADMISSION OF ANY LIABILITY ON THE PART OF GULF AIR.
   THE ATTENDANT IS TO ENSURE THAT ALL ITEMS OR MEDICAL EQUIPMENT BROUGHT INTO THE AIRCRAFT WITH THE PATIENT"INCLUDING NEEDLES, SYRINGES AND UNUSED MEDICATIONS) ARE REMOVED AT THE TIME THE PATIENT IS DISEMBARKED FROM THE AIRCRAFT.
   SIGNATURE OF THE PASSENGER……

MEDICAL Please ensure that you read note 10 overleaf (COMPILED BY PASSENGERS DOCTOR-TYPED OR IN BLOCK CAPITALS)

4. Passenger`s Doctor……..Tel.No: ……
5. Patient: Male/Female (delete as applicable) Age…….Date of Onset of Illness……
6. Height……CM……Weight……kg
7. Diagnosis……
   - Resolved YES NO
   - Stable and controlled YES NO
8. Is the disease contagious or infectious in any form? NO YES, if yes explain below
   ……
9. Present Symptoms……
   ……
10. Prognosis For the flight……
    ……
11. a. BP…… b. HB…… C. Dyspnoea NIL/Mild/Severe (delete as applicable)
12. Give details of any drug therapy ……
13. State requirements for especial treatment and/or oxygen. (Oxygen flow rate in litre per minute)
    a. In flight…… b. At ground stops……
14. Does patient have full control of Bowels/Bladder? YES/NO (delete as applicable)
15. Can patient eat and drink unaided? YES/NO (delete as applicable)
16. Can patient use the aircraft toilet unaided? YES/NO (delete as applicable)
17. Does patient require a wheelchair? YES/NO (delete as applicable)
    If yes, which of the following? a. Aircraft steps b. to the cabin door c. to the seat (delete as applicable)
18. Does patient require Doctor/Qualified Nurse/Non Medical escort YES/NO (delete as applicable)
19. Is patient accompanied? If so by whom?
20. Details of Ambulance/Hospitalization arrangements at destination, if necessary.
    a. Ambulance supplier……(i) At embarkation……..
    b. Hospital……(ii) At destination……
    c. Whether confirmation given to passenger with reference……
21. Does the condition of the patient (mental/physical) will cause discomfort/distress to the rest of the passenger? NO YES, if yes please specify……
22. Can the patient use normal aircraft seat with seatbelt in upright position when required?
    NO if no please specify……YES
23. Other remarks/information in the interest of patient comfortable transportation
    None YES, if yes please specify……
24. Hospitalization
    Admission…….. Date of surgery, if any……
    Discharge……
25. In case of fracture: Mode of treatment……
    (POP) location……..
26. Above details completed by Dr. ……..Date……..
    Signature…….. Date:
27. If cardiac disease:
    EF%……
28. Any Medical equipment used during flight ----------
29. If passenger is pregnant, please fill up the following;
    Medical history……..
    LMP…… Duration/week……
    EDD…… Complications: Yes /No Reason……

To attach recent detailed medical report in English