Fit For Travel Medical Certificate

Name .....

.....

HN ..... Date .....

Birth Date ..... Age .....

Room ..... Sex .....

Physician .....

Date of Examination ..... Time .....

To Whom It May Concern:

This is certify that above name's patient has examined and treated at our hospital as an:

☐ Out patient ☐ in-patient on/during .....

Diagnosis : .....

.....

Travel Recommendation and Assessment (Please tick in the box):

☐ Fit to fly as normal seated passenger

☐ Fit to fly with medical escort(s) only

☐ Fit to fly with non-medical escort/family

☐ Not fit to fly/Travel only at patient's own risk

Special requirement(s), (Please tick in the box):

☐ None

☐ Economy class ☐ Business class ☐ First class Stretcher

☐ Wheelchair ☐ to Step ☐ to Ramp to Seat (Cabin) ☐ Oxygen supply

☐ Others (Please specify) .....

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Physician's Signature ..... Medical License No ..... Telephone .....

I understand the risk(s) involved in air travel and accept full responsibility for myself

.....	.....	.....
Signature, Patient	Full name (Block letters)	Date
.....	.....	.....
Other legally authorization	ID Number/Passport Number	Relationship to patient
.....	.....	.....
Language used Translation (If required)	Witness/Translator	Witness

Note: the final decision on whether or not the patient is allowed to board the plane mainly relies on the concerned airline