MEDIF

Standar medical information form for air travel

Answer all questions. Put a cross (X) in ‘Yes or No’ boxes. Use block letters or typewriter when completing this form

Part 1

To be completed by Agent/Sales Office/Passenger

A Name/Initials/Title:

B Proposed itinerary (airlines(s), flight number(s), class(es), date(s), segment(s), reservation status of continuous air journey):

Transfer from one flight to another often 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)
    Yes [ ] No [ ]
    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 Wheelchair needed? Categories are WCIR, WCHS, WCHC:
    Own Wheelchair?  No [ ] Yes [ ]
    Collapsible?  No [ ] Yes [ ]
    Power driven?  No [ ] Yes [ ]
    Battery type (spillable)  No [ ]

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

Wheelchair category

G Ambulance needed?
    Yes [ ] No [ ] Specify destination address
    Request rate (s) if unknown

H Other ground arrangements needed
    Yes [ ] No [ ] Specify

1. Arrangements for delivery at airport of departure
    No [ ] Yes [ ] Specify

2. Arrangements for assistance at connecting points
    No [ ] Yes [ ] Specify

3. Arrangements 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.

L Does passengers hold a ‘Frequent Traveller’s medical card’ valid for this trip? (FREMEC)
    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.

Passenger’s declaration

I hereby authorize (name of nominated physician)

to provide the airlines with the information required by those airlines’ medical departments 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 fees 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 my own risk, to bear any consequences which carriage by air may state of health and I release the carrier, its employees, servants and agent(s) from any liability for such consequences.

I agree to reimburse the carrier(s) upon demand for any special expenditures or costs in connection with may 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 __________________________
### MEDIF Medical Information Sheet

**RETURN THIS FORM TO**: This form is intended to provide confidential information to enable the airline medical departments to assess the fitness of 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). Completion of the form in block letters or by typewriter will be appreciated.

<table>
<thead>
<tr>
<th><strong>AIRLINES’ REF. CODE</strong></th>
<th><strong>MEDA 01</strong></th>
<th><strong>PATIENT’S NAME, INITIAL(S), SEX, AGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDA 02</strong></td>
<td><strong>ATTENDING PHYSICIAN NAME AND ADDRESS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TELEPHONE CONTACT</strong></td>
<td><strong>BUSINESS</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 03</strong></td>
<td><strong>MEDICAL DATA</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>DIAGNOSIS IN DETAILS</strong> (including vital signs)</td>
<td></td>
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<tr>
<td><strong>MEDA 04</strong></td>
<td><strong>DATE OF DIAGNOSIS</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 05</strong></td>
<td><strong>PROGNOSIS FOR THE TRIP</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 06</strong></td>
<td><strong>CONTAGIOUS AND COMMUNICABLE DISEASE</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 07</strong></td>
<td><strong>WOULD THE PHYSICAL AND/OR MENTAL CONDITION OF THE PATIENT BE LIKELY TO CAUSE DISTRESS OR DISCOMFORT TO OTHER PASSENGERS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MEDA 08</strong></td>
<td><strong>CAN PATIENT USE NORMAL AIRCRAFT SEAT WITH SEAT-BACK PLACED IN THE UPRIGHT POSITION WHEN SO REQUIRED</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 09</strong></td>
<td><em><em>CAN PATIENT TAKE CARE OF HIS OWN NEEDS ON BOARD UNASSISTED</em> (INCLUDING MEALS, VISIT TO TOILET, ETC.)?</em>*</td>
<td></td>
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<tr>
<td><strong>MEDA 10</strong></td>
<td><strong>IF TO BE ESCORTED, IS THE ARRANGEMENT PROPOSED IN PART 1/E OVERLEAF SATISFACTORY FOR YOU?</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 11</strong></td>
<td><strong>DOES PATIENT NEED OXYGEN</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MEDA 12</strong></td>
<td><em><em>DOES PATIENT NEED ANY MEDICATION</em>, OTHER THAN SELF-ADMINISTERED, AND/OR THE USE OF SPECIAL APPARATUS SUCH AS RESPIRATOR, INCUBATOR ETC</em>*</td>
<td></td>
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<tr>
<td><strong>MEDA 13</strong></td>
<td><strong>DOES PATIENT NEED HOSPITALISATION? (IF YES, INDICATE ARRANGEMENTS MADE OR, IF NONE WERE MADE INDICATE ‘NO ACTION TAKEN’)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MEDA 14</strong></td>
<td><strong>OTHER REMARKS OR INFORMATION IN THE INTEREST OF YOUR PATIENT’S SMOOTH AND COMFORTABLE TRANSPORTATION</strong></td>
<td></td>
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<tr>
<td><strong>MEDA 15</strong></td>
<td><strong>OTHER ARRANGEMENTS MADE BY THE ATTENDING PHYSICIAN</strong></td>
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</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th><strong>ATTENDING PHYSICIAN’S NAME</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>ADDRESS</strong></td>
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<tr>
<td><strong>DATE</strong></td>
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<tr>
<td><strong>SIGNED</strong></td>
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</tbody>
</table>

**APPROVED BY GARUDA INDONESIA MEDICAL DEPARTMENT**

**ADDRESS**: Date :
**SIGNATURE**: Name :
**PHONE**: Date :

Garuda Indonesia Medical Center
Telephone: 62-21-4241000
Ext.: 6136 (office hours), 6103 (out of office hours)
Facsimile: 62-21-4245809 (office hours)
4245604 (out of office hours)

QRF/Medif/TC.6/Rev.01/01/2014
MEDICAL CERTIFICATE

NAME PATIENT : ................................................. (full name)
DATE OF BIRTH : .................................................
ADDRESS : ..........................................................
TELP : ................................................................

PATIENT HISTORY / COMPLAINT :

VITAL SIGNS :
GCS : ........... TEMPERATURE: ...... RESPIRATORY RATE : ...........
BLOOD PRESS : ...........mmHg PULSE RATE : ...........Sa O2 : ...........

PHYSICAL EXAMINATION : (HEAD, CHEST, ABDOMEN, EXTREMITY, Etc.)

OTHER EXAMINATION (RADIOLOGY, LAB, ECG, CT SCAN, USG, Etc.)

DIAGNOSIS :

TREATMENT / MEDICATION :

PATIENT REQUEST FOR REPATRIATION / MEDICAL EVACUATION : Yes / No
IN DOCTOR’S OPINION THIS MEDICALLY NECESSARY : Yes / No
PATIENT CAN TRAVEL : Yes / No

PATIENT CAN TRAVEL □ Unescorted □ With Medical escort □ With Not Medical escort

PATIENT NEED □ Ordinary seat □ Wheelchair Assistance □ Stretcher Case

DOCTOR’S RECOMMENDATION:

ATTENDING PHYSICIAN

QRF/Medif/TC.6/Rev.01/01/2014

Signature & name in block letter