

Medical Certificate of Fitness for Air Travel (MEDIF form)

This form is intended to provide confidential information to enable the airline Medical Doctor to assess the fitness for travel and provide for the passenger's special needs. It must be dated not more than one month prior to date of flight departure.

The physician attending the incapacitated passenger is requested to answer all questions.
Put a cross (X) in 'Yes' or 'No' boxes. Use BLOCK LETTERS or TYPEWRITER when completing this form.

ITEM 1	Passenger's Name:	SEX:	AGE:
	Address:	Phone(H):	Mobile:
	Email:		
	Itinerary – Flight Details Mandatory		Booking Reference:
	Flight No:	Date:	From: To:
	Flight No:	Date:	From: To:
Note: Transfer from one flight to another requires LONGER connecting time.			
To be completed by Attending Physician/Treating Doctor:			
ITEM 2	Attending Physician/Treating Doctor Name of Hospital or Clinic (if relevant)	Name:	
		Address:	
		Email:	
		Business:	HOME:
ITEM 3	NATURE OF INCAPACITATION:	Medical Clearance required if patient non autonomous.	
		Can patient travel in a sitting position for the duration of flight?	
		<input type="checkbox"/>	<input type="checkbox"/>
		NO	YES
Whether infectious?			
<input type="checkbox"/>	<input type="checkbox"/>		
NO	YES		
Whether patient has full control of bowels & bladder?			
<input type="checkbox"/>	<input type="checkbox"/>		
NO	YES		
	Diagnosis of condition:		
	Present Symptoms:	Whether patient displays suicidal tendencies or is subject to fits of violence?	
		<input type="checkbox"/>	<input type="checkbox"/>
		NO	YES

ITEM 4	Wheelchair Needed? <input type="checkbox"/> NO <input type="checkbox"/> YES →	<table border="1"> <thead> <tr> <th><u>OWN Wheelchair</u></th> <th><u>Collapsible</u></th> <th><u>Power Driven</u></th> <th><u>Battery type (Spillable)</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> NO</td> <td><input type="checkbox"/> NO</td> <td><input type="checkbox"/> NO</td> <td><input type="checkbox"/> NO</td> </tr> <tr> <td><input type="checkbox"/> YES</td> <td><input type="checkbox"/> YES</td> <td><input type="checkbox"/> YES</td> <td><input type="checkbox"/> YES</td> </tr> </tbody> </table>	<u>OWN Wheelchair</u>	<u>Collapsible</u>	<u>Power Driven</u>	<u>Battery type (Spillable)</u>	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
	<u>OWN Wheelchair</u>	<u>Collapsible</u>	<u>Power Driven</u>	<u>Battery type (Spillable)</u>										
<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO											
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES											
Categories are: WCHR (wheelchair ramp) WCHS (wheelchair step) WCHC (wheelchair Cabin) Wheelchair category: <input type="text"/> (If answer is 'YES', then you should fill in the next columns).	Wheelchairs with spillable batteries are "dangerous goods" and are permitted on passenger aircraft only under certain conditions, which can be obtained from the airline(s). Wheelchairs are stowed in the aircraft hold. Wheelchair and battery must be claimed and rechecked at each interline transfer point If own wheelchair, is it: WCMP (manual power) WCBD (dry cell battery) WCBW (wet cell battery)													
ITEM 5	Cardiac Cases: Nature of Treatment													
ITEM 6	IS STRETCHER NEEDED ON BOARD? (All stretcher cases must be escorted by trained medical personnel & always require <u>completion</u> of MEDIF form).	<input type="checkbox"/> NO	<input type="checkbox"/> YES											
	Intended Escort (Name, professional qualification):													
ITEM 7	IS OXYGEN NEEDED ON BOARD? Specify rate of flow (Litres per minute)	<input type="checkbox"/> NO	<input type="checkbox"/> YES											
		All details as to amount of oxygen required on board i.e. debit litres per minute/continuous/intermittent or only at take off /landing should be specified. Flow Rate to be specified. <input type="text"/> Litre per minute (L/M)												
		Continuous:												
		Intermittent:												

ITEM 8	<p>If an Ambulance is required, have all the necessary arrangements been made?</p> <p>Note:</p> <p>Only Air Mauritius oxygen bottles/cylinders are accepted for use onboard. Alternative arrangements SHOULD be made for provision of oxygen on ground or during TRANSIT.</p>	<p>To be arranged by SPONSOR:</p> <p style="text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> NO YES </p> <p>a) during long layover or night stop at CONNECTING POINTS en route</p> <p style="text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> NO YES </p> <p>(b) upon arrival at DESTINATION</p> <p style="text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> NO YES </p>
	Specify Details:	
ITEM 9	<p>Life Support Equipment:</p> <p>Does patient need the use of SPECIAL EQUIPMENT such as respirator, nebulizer, defibrillator, ventilator etc.</p>	<p>To be arranged by SPONSOR:</p> <p style="text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> NO YES </p> <p>(Electrical equipment must be MK authorized for <u>safety & security</u> reasons.)</p>
	Specify Details:	
ITEM 10	<p>Other arrangements made by the attending physician:</p>	

It is certified that in my opinion the above named is medically fit to travel by air from to and that the patient will not, in any way, adversely affect the welfare and comfort as well as endanger the lives of other passengers.

Attending Doctor's name:

Signature: **Date:**

I hereby indemnify and hold AIR MAURITIUS harmless from and against any liability arising out of any bodily injury and/or death, damage or loss that I may suffer and against any other damage, payments, of accepting me for carriage on its flights, and I do hereby undertake to repay AIR MAURITIUS 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 AIR MAURITIUS shall be solely for my welfare and will be without prejudice and entirely without admission of any liability on the part of AIR MAURITIUS.

Signature of Passenger **Date:**

Remarks of Airline Medical Doctor:

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Address: Clinic Fortis Darné Phone No: 601 2300 Fax No: 696 1209

Signature: **Date:**