This form is interactive. You can type your information into the form and then print before you sign. If you fill in by hand, be sure to print legibly; this will help avoid processing delays.

Fees for completion of this form are the responsibility of the patient.
Please fill in completely and date where requested; incomplete forms will not be reviewed or processed. Submit completed forms to WestJet by e-mail to meddesk@westjet.com or by fax to 1-866-737-1202

PATIENT INFORMATION

First name | **Last name** | **Birthdate** MM/DD/YYYY

E-mail | **Contact number**

Address | **City**

Province/state | **Postal code/ZIP** | **Country**

WestJet OP Number *(only if you have had a previous accommodation approval)*

WestJet ID *(optional but will aide in our provision of some services)*

Intended date of travel MM/DD/YYYY | **Flight origin** | **Flight destination**

ALTERNATE CONTACT

Does the patient prefer or require that we speak with someone else for follow up questions? The patient and anyone listed here will have access to, and may be advised of, your medical information.

Name | **Relationship**

E-mail *(if different than patient's)* | **Contact number** *(if different than patient's)*

Patient name

PREVIOUS TRAVEL HISTORY

Have you ever flown on a commercial aircraft in the medical condition/injury indicated on this form?	☐ No	☐ Yes
How did you travel?	☐ Alone	☐ Accompanied

When?

Have you suffered from any medical complications that required medical intervention during a commercial flight?
If yes, please provide date and details/explain.

PATIENT CONSENT AND AGREEMENT

I _____ consent and authorize my treating medical professionals to provide and discuss the information on this form, other medical information or my previous travel history with WestJet as required to facilitate my safe air travel. This consent and authorization extends to any medical professional holding information relevant to my assessment by WestJet, or any support organization arranging travel on my behalf. I consent to the collection and retention of the medical information on this form for the purposes of facilitating travel, with the understanding that this medical information will be kept confidential in accordance with WestJet's Privacy Policy.

I understand that if approved, WestJet will provide appropriate accommodations to me. I agree to provide updated medical information for any significant change(s) to my health, and to abide by the terms of any medical accommodation including personal attendant requirements and restrictions applicable to travel companions.

Signature *(patient/guardian/or decision maker)*	**Date** MM/DD/YYYY

WESTJET

Patient name

PHYSICIAN DETAILS

All remaining must be completed by a medical physician.

Physician name	**License number**

Province/Country of registration	**Town/City**

E-mail *(optional)*

Contact number	**Fax**	**Date of first visit** MM/DD/YYYY

Is the patient regularly in your care? ☐ No ☐ Yes

If there is another medical professional or support organization with whom WestJet may need to discuss information relevant to your patient's fitness to fly please provide their information below. Include all occupation(s) and contact information (e-mail/phone numbers)

Complete the applicable sections, initial each page at the bottom and sign on page 9.
Attach additional documentation or information if required. Please select the applicable statement for your patient and complete as directed.

My patient is requesting

☐ Confirmation they are fit to fly	*Complete section 1*
☐ An allergy buffer zone	*Complete section 1*
☐ Seating	*Complete sections 1 and 4*
☐ An extra seat for obesity	*Complete sections 1, 2 and 4*
☐ A personal attendant	*Complete sections 1, 3 and 4*
☐ An accomodation inflight to or from the United States	*Complete section 4*

Physician initials	**Date**

WESTJET

Patient name

SECTION 1: FIT TO FLY INFORMATION

Section 1 is required for all patients, except those travelling to/from the U.S.
Note: Although section 1 is not required for travel to/from the U.S., we recommend that it is completed to ensure safety for travel and assess if on board accommodations are required.

Diagnosis

Date of onset MM/DD/YYYY

Current symptoms and severity

Treatment/prescribed medication(s)

Recent, relavant or planned surgery/sedation ◯ No ◯ Yes

Nature

Date MM/DD/YYYY

Currently hospitalized? ◯ No ◯ Yes

If yes, discharge to ◯ Home ◯ Facility

Date of discharge MM/DD/YYYY

Allergies

◯ Not applicable (skip) ◯ Yes - Please complete the following

Allergen	Symptom	Allergen	Symptom
	☐ Hives		☐ Hives
	☐ Sneezing		☐ Sneezing
	☐ Anaphylaxis		☐ Anaphylaxis
	☐ Asthma attack		☐ Asthma attack

Physician initials

Date

WESTJET

Patient name

Pulmonary

◯ Not applicable (skip) ◯ Yes - Please complete the following

Condition Type

Does the patient have shortness of breath?

☐ No ☐ Yes, with light efforts

☐ Yes, with major efforts ☐ Yes, at rest

Has the patient deteriorated recently? ◯ No ◯ Yes

Details

Oxygen saturation

% L/min continuous oxygen ☐ Room air

Max L/min required during flight

Does the patient use oxygen at home? ◯ No ◯ Yes

Will your patient require oxygen inflight? ◯ No ◯ Yes

Is your patient using a personal oxygen concentrator (POC)? ◯ No ◯ Yes

For usage of gaseous oxygen or a personal oxygen concentrator, please see westjet.com/oxygen for documentation requirements and restrictions. WestJet does not supply oxygen for purchase onboard our aircraft.

Physician initials

Date

WESTJET

Patient name

Cardiac

◯ Not applicable (skip) ◯ Yes - Please complete the following

Condition Type

A. Angina

◯ No ◯ Yes

Date MM/DD/YYYY

The patient's condition is ◯ Stable ◯ Unstable

If unstable, please select one

◯ No symptoms ◯ Angina at rest ◯ Angina w/major effort ◯ Angina w/ minor effort

B. Myocardinal infraction

◯ No ◯ Yes

Date MM/DD/YYYY

Complications ◯ Stable ◯ Unstable

Angiogram/Angioplasty ☐ Angiogram ☐ Angioplasty

Procedure date MM/DD/YYYY

C. Cardiac failure

◯ No ◯ Yes

Class 1-4

Other details

D. Syncope

◯ No ◯ Yes

Last episode MM/DD/YYYY

Investigations ◯ No ◯ Yes ◯ Undiagnosed

If investigated, result/cause

Physician initials

Date

Seizures

◯ Not applicable (skip) ◯ Yes - Please complete the following

Type

Frequency

Date of last seizure MM/DD/YYYY

Are the seizures stable and controlled by medication? ◯ No ◯ Yes

Is oxygen or suction required to manage the seizure? ◯ No ◯ Yes

Cognitive/behavioral or psychiatric

◯ Not applicable (skip) ◯ Yes - Please complete the following

Condition type/explain

Is there a possibility the patient's condition will deteriorate during flight? ◯ No ◯ Yes

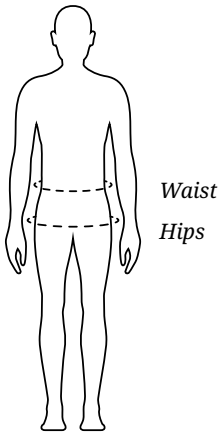
If yes, please explain

Please complete section 4 if an attendant would mitigate the patient's condition.

SECTION 2: SEATING ACCOMMODATIONS FOR OBESITY

◯ Not applicable (skip) ◯ Yes - Please complete the following

Height	**Weight**
cm	kg
Waist around umbilicus	**Maximum girth around hips above gluteal fold**
cm	cm



Physician initials **Date**

WESTJET

Patient name

SECTION 3: ASSISTANCE REQUIREMENTS

◯ Not applicable (skip) ◯ Yes - Please complete the following

Once onboard the aircraft, is your patient capable of:

Taking prescription medication unaided?	◯ No	◯ Yes
Using the toilet unaided (once inside the lavatory)?	◯ No	◯ Yes
Managing their meals unaided?	◯ No	◯ Yes

If no, what assistance is required? ☐ Feeding ☐ Opening containers ☐ Set-up/orientation

Does your patient require a medically qualified attendant in order to travel?	◯ No	◯ Yes

Indicate what specific assistance your patient requires:

Wheelchairs and transfers

Do not use this form to request the use of a wheelchair. See westjet.com/wheelchairs for advance notice requirements and more information.

Will your patient require a wheelchair for

☐ Distance ☐ Transfer from door aircraft to their seat ☐ At all times

Can your patient self-transfer to/from a wheelchair to the seat of the aircraft?	◯ No	◯ Yes
Can your patient stand, pivot and weight bear?	◯ No	◯ Yes
If transfer assistance is required, can your patient be transferred using a mechanical lift? (Note: WestJet cannot transfer patients exceeding 200kg/440lbs)	◯ No	◯ Yes

If no, why?

Physician initials **Date**

WESTJET

Patient name

SECTION 4: MANDATORY FOR ALL PATIENTS

If your patient consents to providing WestJet with additional medical information, we strongly recommend that you complete section 1 as this will help us ensure your patient's safety in the aircraft's relative hypoxic environment, and will improve our ability to identify any onboard accommodation that may be required/available.

Prognosis for a safe flight with no extraordinary medical attention

☐ Good

☐ Poor if the patient has any of the following:
a) An unstable medical condition
b) A medical condition that may worsen at altitude in a hypoxic environment
c) May require medical assistance or emergency medical equipement during flight

Is your patient fit to fly? ☐ No ☐ Yes

Communicable disease

Does the patient have an active communicable infection/disease that can be transmitted or pose a direct threat to the health and safety of other individuals during the normal course of their travel?

☐ Not applicable (skip) ☐ Yes - Please complete the following

Condition type/explain

Are there any precautions needed to prevent the spread of infection or disease during the course of thier travel? ☐ No ☐ Yes

Explain

Does the patient have a fused knee or immobilized lower limb? ☐ No ☐ Yes

If yes, we may request further medical information to provide this accommodation.
You may opt to complete section 1: fit to fly information.

PHYSICIAN'S CONSENT

By signing this form, I understand that I am providing information which WestJet will use to determine my patient's ability and/or accommodations needed to travel safely. I accordingly certify that all of the information I have provided is complete, true and accurate to the best of my knowledge. If only section 4 is completed, this must be dated within 10 days of travel and travel must be completed within 10 days of approval.

Signature

Date MM/DD/YYYY