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 form are the responsibility of the guest/patient.

Please fill in completely and date where requested; incomplete forms will not be reviewed or processed.

Guest information section - to be completed by guest/patient

Enter name exactly as shown on travel identification (generally a passport).

Important notes:

- If the guest chooses to purchase additional or special seating and is not subsequently approved before travel, WestJet will not give a refund, credit or other compensation. If the guest is not approved before the flight, the change or cancellation fees and guidelines for the flight segments reserved will apply.
- **The final determination of a guest's fitness to fly will be made by the WestJet medical team** after reviewing all medical information provided by the guest and physician.
- This form's sole use is to determine accommodation(s) provided by WestJet for WestJet marketed and operated flights. This will not provide accommodations for services offered by third party vendors, suppliers or tour operators.
- Oxygen required: If you only require oxygen but no other accommodation do not use this form. You must supply your own oxygen or portable oxygen concentrator and you may need to bring a separate letter from your physician to the airport. See westjet.com/oxygen for details and restrictions.

Submit completed forms to WestJet by fax at 1-866-737-1202 or email meddesk@westjet.com

***Guest first name:** | ***Guest last name:** | **Title** | ***Birthdate:** (MM/DD/YYYY)

***Gender:** | ***Preferred contact number:** | **Alternate contact number:**

***Preferred email:** | **Alternate email:**

***Guest address:** | ***City:**

***Province/State:** | ***Postal code/Zip:** | ***Country:**

***Have you previously been approved for an OP number?**

○ No ○ Yes

If yes, what is your OP number:

Guest's WestJet ID: (9-digits)

WestJet strongly encourages all guests with medical accommodations to provide their WestJet ID as this aids in our provision of some services.

Intended date of travel: (MM/DD/YYYY) **From:** **To:**

Alternate contact

If you would prefer that we speak with someone else for follow up questions, please provide their details below. Only you and this person will be able to access your information.

Name: **Relationship to guest:**

Contact number: (If different than guest's) **Email:** (If different than guest's email)

Consent and agreement

I _____ consent and authorize my treating medical professionals to provide and discuss the information on this form or other medical information 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 (guest/guardian/or decision maker):** ***Date:** (MM/DD/YYYY)

Interpreter

Understanding and consent from a non-English speaking guest

I acknowledge that I have interpreted the information on this form to the person giving consent and I believe that the person understands the information provided and consents to the disclosure of this information by their treating medical physician to WestJet.

Name: **Signature:** **Date:** (MM/DD/YYYY)

Medical physician (MD) details

All remaining pages must be completed by a medical physician.

***Required fields**

***Medical physician (MD) name:**

***License number:**

***Country or province of registration:**

***Physician's location (town or city):**

Email address:

***Phone number:**

***Fax:**

Date of first visit: (MM/DD/YYYY)

Is this patient regularly in your care:

○ No ○ Yes

***Is your patient able to walk 50 metres without experiencing moderate to severe respiratory distress?**

○ No ○ Yes

***Is your patient fit to fly?**

○ No ○ Yes

Please elaborate:

Please select the applicable statement for your patient and complete as directed.

My patient is requesting:

☐ an on-board accommodation for _____ Complete Section 1.

☐ a personal attendant inflight. Complete Sections 1 and 2.

☐ an extra seat for obesity. Complete Section 1 and 3.

☐ an accommodation during travel to or from the United States. Complete Section 5.

I acknowledge that the aircraft cabin is pressurized to between 6000 - 8000 ft above sea level and any individual with cardiac or pulmonary conditions may deteriorate. I am aware that air travel is not appropriate for patients that need access to advanced medical care or have a serious illness or are at risk for complications. Access to ground medical services will be dependent on flight destination and duration. Patients with medical considerations that run the risk of causing a flight diversion must postpone travel or travel by air ambulance.

I confirm that the above named patient is under my care and in my opinion they are capable of travelling by air without requiring extraordinary medical assistance.

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 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:

Please include all occupation(s) and contact information (email/phone numbers):

***Signature:**

***Date:** (MM/DD/YYYY)

Section 1: Fit to fly information

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

***Primary diagnosis:**

***Date of onset:** (MM/DD/YYYY)

Secondary diagnosis:

***Current symptoms and severity:**

***Treatment and prescribed medication:**

***Recent, relevant or planned surgery/sedation:**

◯ No ◯ Yes

Nature:

***Date:** (MM/DD/YYYY)

***Compliant with treatment?**

◯ No ◯ Yes

Currently hospitalized?

◯ No ◯ Yes

Date of discharge? (MM/DD/YYYY)

Discharge to:

◯ Home ◯ Facility

***Disabling allergies to cats?**

◯ No ◯ Yes

If yes, please specify symptoms, treatment and stability for travel:

Wheelchairs, transfers and medical equipment

*Is a wheelchair required by your patient?

- ◯ No
- ◯ Yes, at all times and requires transfer to/from seat
- ◯ Yes, for distance only; can climb steps (>50 metres)
- ◯ Yes, for distance; can't climb steps

Can your patient self-transfer to/from a wheelchair to the seat of the aircraft?

◯ 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? _____

Please list any medical equipment your patient will require during the flight:

_____

Chronic pulmonary condition

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

a) Does patient have shortness of breath?

◯ No ◯ Yes, with major efforts ◯ Yes, with light efforts ◯ Yes, at rest

b) Has the patient deteriorated recently?

◯ No ◯ Yes

Details: _____

Oxygen saturation:

_____ % ◯ Room air ◯ Oxygen _____ L/min continuous oxygen

Measured via:

◯ Nasal prongs ◯ Mask

Max L/min required during flight: _____

Does the patient use continuous oxygen at home?

◯ No ◯ Yes

Will your patient require continuous oxygen inflight?

◯ No ◯ Yes

Is your patient using a personal oxygen concentrator (POC)?

◯ No ◯ Yes

Cardiac condition

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

a) Angina **Date:** (MM/DD/YYYY) **The patient's condition is:**

◯ No ◯ Yes ◯ Stable ◯ Unstable

If unstable, please select one:

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

b) Myocardial infarction **Date of event:** (MM/DD/YYYY) **Complications:**

◯ No ◯ Yes ◯ No ◯ Yes

Angiogram/angioplasty: **Procedure date:** (MM/DD/YYYY)

☐ Angiogram ☐ Angioplasty

c) Cardiac failure **Class 1-4:** **Other details:**

◯ No ◯ Yes

d) Syncope **Last episode:** (MM/DD/YYYY) **Investigations:**

◯ No ◯ Yes ◯ No ◯ Undiagnosed ◯ Yes

If investigated, result/cause:

Seizures

Type: **Frequency:** **Date of last seizure:**

◯ Not applicable ◯ Yes (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 conditions

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

Diagnosis/explain: (250 character limit)

Is there a possibility that the patient will become agitated during flight?

◯ No ◯ Yes

If yes, please explain:

If yes, and an attendant would mitigate their condition, please complete Section 2. Additional comments:

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

Diagonosis/explain:

(250 character limit)

Are any precautions needed to prevent the spread of infection or disease during the course of their travel?

◯ No ◯ Yes **Specify:**

***Has the patient ever flown on a commercial aircraft with the medical condition/injury indicated on this form?**

◯ No ◯ Yes

When: (MM/DD/YYYY)

***How did they travel?**

◯ Alone ◯ With attendant

Has your patient ever suffered from any problems/medical complications during a commercial flight?
If yes, please explain:

(Provide date and details)

Section 2: Assistance requirements

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

If yes, indicate what specific assistance your patient requires and complete the below.

Medical reason why your patient cannot travel alone?

Once onboard the aircraft, is your patient capable of:

Using the toilet unaided (once inside the lavatory)? ◯ No ◯ Yes

Taking prescription medication unaided? ◯ No ◯ Yes

Managing their meals unaided? ◯ No ◯ Yes

If no, what assistance is required? Check all that apply.

☐ Feeding ☐ Opening containers ☐ Set-up/orientation

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

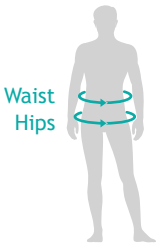
Section 3: Seating accommodations for obesity

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

We require five days to adjudicate.

☐ **Extra seats(s) for obesity** (must also complete Section 1: Fit to fly information)

Provide the patient's circumference (taken while standing):



Height:	**Weight:**	**Waist at umbilicus:**	**Maximum girth of hips above gluteal fold:**
____ cm	____ kg	____ cm	____ cm

Section 4: Additional medical information

◯ Not applicable (skip) ◯ Yes - Please add any additional medical information you feel is relevant to your situation or your accommodation request.

Section 5: Travel only between Canada and the USA.

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

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.

1. Prognosis for a safe flight with no extraordinary medical attention:

◯ Good ◯ Poor - if the patient has any of the following:
a) Has an unstable medical condition;
b) Has a medical condition that may worsen at altitude in a hypoxic environment
c) May require medical assistance or emergency medical equipment during flight

2. Communicable diseases

Does the patient have a communicable infection or disease that would under their current status, be transmitted or pose a direct threat to the health and safety of other individuals during the normal course of their travel?

◯ No ◯ Yes

Are there any precautions needed to prevent the spread of infection or disease during the course of their travel?

◯ No ◯ Yes Specify:

3. 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 - Fitness to travel.

◯ No ◯ Yes

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.

Signature:

Date: (MM/DD/YYYY)

*If only Section 5 is completed, this must be dated within 15 days of travel and travel must be completed within 15 days of approval.