



This form is to certify that a guest has a physical or medical condition that prevents them from wearing a non-medical mask or face covering for air travel on board WestJet operated flights.

WestJet Medical Desk

Email: meddesk@westjet.com

Fax: 1-866-737-1202

This form is fillable and includes fields that you can edit before you print and sign. You can also print this form and complete it by hand. Please be sure to print legibly to avoid processing delays.

Fees for completion of this form are the responsibility of the guest/patient.

Please note: incomplete forms will not be reviewed. Completed forms must be sent to WestJet's Medical Desk via email to meddesk@westjet.com or fax at 1-866-737-1202.

GUEST INFORMATION

Last name <i>(provide name exactly as shown on travel identification)</i>		First name	Middle name
Birthdate MM/DD/YYYY	E-mail	Contact number	
Address		Town/City	
Province/State	Postal code/ZIP	Country	
Existing WestJet OP Number <i>(if applicable)</i>		WestJet Rewards ID <i>(optional but will aide in the arrangement of some services)</i>	
Intended date of travel MM/DD/YYYY			

ALTERNATE CONTACT

Please provide an alternate contact (a parent, guardian or decision maker) if guest is a child or cannot advocate for themselves. The alternate contact may speak on guest's behalf for follow up questions and will have access to the result of this application.

Name	Relationship
E-mail <i>(if different than guest's)</i>	Contact number <i>(if different than guest's)</i>

GUEST CONSENT AND AGREEMENT**To be completed by the guest or their legal guardian.**

I hereby confirm and understand that:

If the guest receives authorization not to wear a face covering from WestJet, the guest will need to present a negative molecular* COVID-19 test result at the airport check in and/or boarding gate prior to departure

This test must be performed no earlier than 72 hours prior to the scheduled departure time of the first flight of any same-day itinerary, or the first flight of any direct connecting itinerary

The guest will need another negative molecular* COVID-19 test for their return journey if the departure of their return trip exceeds 72 hours from the time the test was taken

By signing this form, I confirm that the guest has an ongoing professional relationship with the Healthcare Provider on page three (3) and that all the information provided is complete, true, and accurate to the best of my knowledge.

Guest/Legal Guardian signature

Date

MM/DD/YYYY

Submission of this form indicates consent to WestJet's Privacy Policy. Other documentation may be required for travel entering or exiting an international destination.

*Accepted molecular tests include:

- PCR-Polymerase chain reaction
- NAT/NAAT-Nucleic acid amplification test
- RT-LAMP-Reverse Transcription loop-mediated isothermal amplification

HEALTHCARE PROVIDER INFORMATION**To be completed by a professional healthcare provider.**

Healthcare provider name		Name of practice	
Address		Telephone number	
License number	Date license issued	MM/DD/YYYY	Province/State where license issued

HEALTHCARE PROVIDER CONSENT AND AGREEMENT

I am a licensed Healthcare Provider treating the patient named above

I certify that this patient is unable to wear a non-medical mask or face covering due to a medical or physical condition

The patient is fit to fly

I certify that this condition is not related to COVID-19 and that this patient is free of any infectious illness

Is the medical condition deemed permanent? No Yes

Medical condition preventing the use of a non-medical mask or face covering *(must be completed)*

I understand that the wearing of a mask during flight is a legal requirement imposed by Transport Canada and that a monetary penalty of up to \$5,000 can be imposed if a person does not comply with this requirement for a reason not following one of the reasons set up by the order

I accordingly certify that all the information I have provided is complete, true, and accurate to the best of my knowledge

Healthcare provider professional signature	Date	MM/DD/YYYY
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Healthcare provider stamp