Accessible Seating Accommodation Form

SUBMISSION GUIDELINES

Seating accommodations are only granted within the cabin your fare was purchased. Any fees for completion of this form are the responsibility of the patient.

To help us meet your travel needs, we recommend **submitting this document at least 48 hours prior** to your departure. For requests made with less advance notice, we'll do our best to accommodate your needs. Both sections of the form must be submitted.

Section 1 - must be completed by you or your parent, guardian, or representative
Section 2 - must be completed by your healthcare provider (i.e., medical doctor, nurse practitioner or physician assistant)

This form is interactive. Only fully completed forms will be reviewed, incomplete forms will not be processed. Submit completed forms to WestJet by email to MedDesk@WestJet.com or by fax to 1-866-737-1202.

SECTION 1 – PASSENGER

To be completed by you (the passenger) or your parent, guardian, or legal representative
Complete electronically or use CAPITAL LETTERS and black ink

Passenger Information

First Name	Last Name	Date of Birth (DD/MM/YYYY) _ _ /_ _ /_ _ _ _
Email	Phone	

Parent, Guardian, or Legal Representative Information
If someone is completing this form on your behalf, please have them enter their information in this section

First Name	Last Name	Relationship to passenger
Email (if different from passenger)	Phone (if different from passenger)	

Authorization and Consent

The following section must be read by/to the passenger and dated and signed by the passenger, or signed and dated by the parent, guardian, or representative who completed the form on the passenger's behalf.

Please review each item below and indicate your consent by adding your signature and the date you completed this form at the bottom of the following section.

Consent for Collection, Use, Disclosure, and Retention of Information

I consent to the collection, use, disclosure, and retention of my personal and medical information by WestJet's Accessibility Services for purposes of facilitating safe travel in accordance with WestJet's Privacy Policy. I understand that my information will be kept confidential and may be retained for three (3) years, as per the *Accessible Transportation for Persons with Disabilities Regulations*, to support future service requests. Please review WestJet's Privacy Policy for more details.

Consent to Discuss Information with Healthcare Providers and Others

By submitting this form, I consent to WestJet discussing and collecting my information with my healthcare provider, family members, or decision-makers (if I am unable to provide consent myself) to ensure appropriate care and accommodation during travel. I also authorize WestJet to share a copy of this authorization and consent with my healthcare provider.

In capital letters, add the first and last name of your dedicated healthcare provider in the space provided.

I hereby authorize _____ to provide WestJet with the personal and medical information required by WestJet's health professional or health service provider for the purpose of assessing my air travel needs.

Passenger, Parent, Guardian, or Representative's Signature	**Date Signed** (DD/MM/YYYY)
x_____	_ _ /_ _ /_ _ _ _

Note: If your medical condition/travel details change in any way from those indicated on this form, you are required to contact WestJet to indicate the information provided in this form is no longer valid, and you will then need to submit a new form before travelling.

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _ /_ _ /_ _ _ _

SECTION 2 – HEALTHCARE PROVIDER

To be completed by **your dedicated healthcare provider** (medical doctor, nurse practitioner or physician assistant)
Complete electronically or use CAPITAL LETTERS and black ink

This form is intended to provide CONFIDENTIAL information to evaluate your patient's medical needs to ensure safe travel and to minimize the risk of any adverse medical event.

As the patient's **designated healthcare provider, you must answer all questions applicable to your patient in the following section.** Enter an "X" in the appropriate "Yes" or "No" box and give concise answers where additional information is required.
Incomplete forms may be returned and could cause a delay in determining acceptance of your patient for air travel.

Patient's Information		
First Name	Last Name	Date of Birth (DD/MM/YYYY) _ _/_ _/_ _ _ _
Healthcare Provider's Information		
First Name	Last Name	Professional Designation
License Number	Province/State of Registration	Country of Registration
Email	Phone	Fax
Diagnosis and Medical Details		
Diagnosis	Medical Details (e.g. type of operation)	

Patient's Prognosis for Flights
(with no extraordinary medical attention)

☐ **Poor Prognosis**	☐ **Good Prognosis**
Indicated by any of the following (please select): ☐ The patient has an unstable medical condition. ☐ The patient has a medical condition that may worsen in an aircraft (i.e. in a hypoxic environment with up to 30% reduction in ambient partial pressure of oxygen, and with cabin pressure approximately 8,000 ft above sea level). ☐ The patient may require medical assistance or emergency medical equipment during the flight.	The patient's medical condition is stable and will not worsen in an aircraft environment, and the patient will not require medical assistance or emergency medical equipment.

Mobility

Do not use this form to request a wheelchair. See our website westjet.com/wheelchairs for advanced notice requirements and more information. If you exceed 200 kg (440 pounds) and require a transfer, then we cannot accept you for travel.

Will your patient require a wheelchair for:

☐ Distance ☐ Unable to ascend/descent steps ☐ 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

Seating accommodation – Seating accommodations are granted within the cabin for which the fare purchased only (based on seating availability). Please indicate seating accommodation request and medical rationale to support (explain onboard limitations and restrictions).

Additional Medical Information – Please provide additional medical information you feel is relevant to your patient's situation or accommodation request.

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _ /_ _ /_ _ _ _