



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

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. Please fill in completely; accommodation decisions will not be made with incomplete forms. Submit completed forms to WestJet by e-mail to MedDesk@WestJet.com or by fax to 1-866-737-1202.

Patient information

| | | | |
|--|---------------------------|--|-------------|
| Last name (provide name exactly as shown on travel identification) | | First name | Middle name |
| Birthdate MM/DD/YYYY | | Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unspecified | |
| E-mail | | Contact number | |
| Address | | Town/City | |
| Province/State | Postal code/Zip | Country | |
| WestJet ID (optional but may aide in the provision of services) | | WestJet OP Number (only if you have had a previous accommodation approval) | |
| Intended date of travel MM/DD/YYYY (mandatory) | Flight origin (mandatory) | Flight destination (mandatory) | |

Alternate contact

Please provide an alternate contact (can be parent, guardian or decision maker) if patient is a child or cannot advocate for themselves. The alternate contact will have access to this medical information and be able to provide details regarding your patient's medical on the patient's behalf.

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

Previous travel history

| | | |
|---|-----------------------------|------------------------------|
| Have you ever flown in a commercial aircraft in the medical condition indicated on this form? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you suffered from any medical complications that required medical intervention during a commercial flight? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes, please provide dates and details

Patient consent and agreement

By signing, printing, or typing my name on the signature line below, I _____ consent to the collection, disclosure, and retention of the medical information on this form and/or information related to an on-board medical event for the purposes of facilitating safe travel, with the understanding that this medical information will be kept confidential in accordance with WestJet's Privacy Policy. I consent and authorize WestJet and my treating medical professionals to provide, receive, and discuss the information on this form, other medical information, or my previous and/or future travel history with WestJet as required to facilitate my safe air travel with WestJet and its subsidiaries. For this purpose, I agree that WestJet may disclose to my treating medical professionals information related to on-board medical event(s) which may have occurred prior or subsequent to my signing of this consent and authorization. This consent and authorization extends to any medical professional holding information relevant to my assessment and/or ability to fly safely with WestJet, which may or may not be the same physician listed in this form, or any support organization arranging travel on my behalf. I understand that if approved, WestJet will provide appropriate accommodations to me for the purposes of my travel with WestJet. I agree to provide updated medical information for any significant change(s) to my health and/or if I experience an on-board medical event, and hereby authorize WestJet to communicate with any medical professional holding information relevant to my ability to safely travel with WestJet following any significant change(s) to my health and/or any on-board medical event. I also agree to abide by the terms of any medical accommodation including personal attendant requirements and restrictions applicable to travel companions.

| | |
|---|-----------------|
| Signature (patient/parent/guardian/or decision maker) | Date MM/DD/YYYY |
|---|-----------------|

Physician details

All remaining must be completed by a medical physician. For a list of medical considerations, please review the [Information for Health Care Providers](#) section on our website. WestJet.com.

| | | | |
|----------------------------------|----------------|----------------|--------------------------------|
| Physician name | | License number | |
| Province/Country of registration | | Town/City | |
| E-mail (optional) | Contact number | Fax | Date of first visit MM/DD/YYYY |

| | | | | | |
|---|-----------------------------|------------------------------|----------------------------------|-----|------|
| Is your patient regularly in your care? | | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, indicate hemoglobin | g/L | Date |
| Requires an attendant | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, complete section 1 | | |
| Requires an extra seat for obesity | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, complete section 1 and 2 | | |
| Severe allergies requiring a buffer zone on board | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, complete section 1.a | | |
| Does your patient have an active communicable disease that can be transmitted or pose a direct threat to the health and safety of others during the normal course of their travel? | | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Will flying on an aircraft at a cruising altitude (2400m/8000ft) above sea level where there is a 25% to 30% decrease in the partial pressure of oxygen (relative hypoxia) affect your patient's medical condition? | | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| If yes, please explain | | | | | |

Prognosis for a safe flight with no extraordinary medical attention

Good

Poor if your patient has any of the following:

- An unstable medical condition
- A medical condition that may worsen at altitude in a hypoxic environment
- May require medical assistance or emergency medical equipment during flight

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 (Physician/Practitioner) | Date MM/DD/YYYY | Physician office stamp required |
| | | |

Section 1: Declaration of medical conditions

| | |
|---|--|
| Diagnosis | Date of onset MM/DD/YYYY |
| Current symptoms and severity | |
| Treatment/prescribed medication(s) | |
| Recent, relevant or planned hospitalization, procedure, surgery or sedation | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Nature of hospitalization procedure, surgery or sedation | Date MM/DD/YYYY |
| Currently hospitalized? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If yes, will be discharged to | <input type="checkbox"/> Home <input type="checkbox"/> Facility |
| Date of discharge MM/DD/YYYY | Hemoglobin g/L Date taken MM/DD/YY |

a. Allergies

Complete only if your patient has a severely debilitating/life threatening allergy that requires a buffer zone accommodation on board the aircraft.

| Allergen | Symptom | Allergen | Symptom |
|----------|--|----------|--|
| | <input type="checkbox"/> Hives | | <input type="checkbox"/> Hives |
| | <input type="checkbox"/> Sneezing | | <input type="checkbox"/> Sneezing |
| | <input type="checkbox"/> Anaphylaxis | | <input type="checkbox"/> Anaphylaxis |
| | <input type="checkbox"/> Asthma attack | | <input type="checkbox"/> Asthma attack |

b. Pulmonary

Condition type

Does your patient have shortness of breath?

No
 Yes, at rest
 Yes, with light efforts of walking 50m
 Yes, with major efforts of walking 50m

Has your patient deteriorated recently?

No Yes

Details

| | | | |
|-------------------|-------------------------|-------------------|-----------------------------------|
| Oxygen saturation | L/min Continuous oxygen | POC pulse setting | <input type="checkbox"/> Room air |
| % | | | |

Does your patient use oxygen at home?

No Yes

| | |
|--------------------|------|
| Physician initials | Date |
|--------------------|------|

If yes, what device does your patient use?

 Oxygen tank

 Personal oxygen concentrator

Flow rate L/min

Pulse delivery settings

Continuous flow rate L/min

Usage hours/day

Usage hours/day

Usage hours/day

Will your patient require oxygen inflight?

 No

 Yes

Max L/min required during flight

Max pulse setting during flight

For usage of a Personal Oxygen Concentrator (POC), please see westjet.com/oxygen for documentation requirements and restrictions. WestJet does not supply oxygen for use on board our aircraft and gaseous oxygen cylinders/oxygen tanks are prohibited on board all WestJet operated flights.

Please confirm that your patient will bring their own POC on board for use during their flight.

 No

 Yes

Can your patient fully manage their POC during flight including responding to alerts and exchanging of batteries?

 No

 Yes

Does your patient have enough batteries to last at least 1.5 times duration of their flight?

 No

 Yes

c. Cardiac

Condition type

Oxygen saturation

%

L/min Continuous oxygen

POC pulse setting

 Room air

Angina

 No

 Yes

Date MM/DD/YYYY

Your patient's condition is

 Stable

 Unstable

If unstable, please select one

 No symptoms

 Angina at rest

 Angina w/major effort

 Angina w/ minor effort

Myocardial infarction

 No

 Yes

Date MM/DD/YYYY

Complications

 Stable

 Unstable

Angiogram/Angioplasty/Bypass

Procedure date MM/DD/YYYY

 Angiogram

 Angioplasty

 Bypass

Cardiac failure

 No

 Yes

NYHA Classification: 1-4

Details

Syncope

 No

 Yes

Last episode MM/DD/YYYY

Investigations

 No

 Yes

 Undiagnosed

If investigated, result/cause

Physician initials

Date

d. Seizures

| Type | Frequency | Duration |
|---|-----------------------------|---|
| Date of last seizure MM/DD/YYYY | | Date of last hospital visit due to seizure MM/DD/YYYY |
| Are the seizures stable and controlled by medication? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is oxygen or suction required to manage the seizure? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| What action is taken to manage the seizure? | | |

e. Cognitive/behavioral or psychiatric

Condition type/explain

| | | |
|---|-----------------------------|------------------------------|
| Is there a possibility your patient's condition will deteriorate during flight? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If yes, please explain | | |
| Is your patient alert and oriented x3 to person, place and time? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If no, complete Assistance requirements | | |

f. Mobility

Do not use this form to request the use of a wheelchair. See our website westjet.com/wheelchairs for advance notice requirements and more information. If you exceed 200 kg (440 pounds) and require a transfer, then we cannot accept you for travel. Please contact WestJet's Special Care Desk as we may be able to assist in making alternative arrangements.

Will your patient require a wheelchair for

Distance Unable to ascend/descend steps At all times

| | | |
|--|-----------------------------|------------------------------|
| Can your patient self-transfer to/from a wheelchair to the seat of the aircraft? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Can your patient stand, pivot and weight bear? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

g. Seating accommodations

Please indicate a seating accommodation request with medical rationale to support.

Physician initials

Date

h. Assistance requirements

Once on board the aircraft, is your patient capable of:

| | | |
|--|----------------------------------|---|
| Taking medication unaided? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Using the toilet unaided (once inside the lavatory)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Managing their meals unaided? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If no, what assistance is required? | <input type="checkbox"/> Feeding | <input type="checkbox"/> Opening containers |
| | | <input type="checkbox"/> Set-up/orientation |

Indicate additional or specific assistance needs your patient requires on board the aircraft:

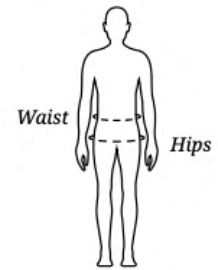
Outline objective medical rationale including your patients medical limitations and restrictions that prevents them from traveling independently once on-board the aircraft

i. Additional Medical Information

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

Section 2: Seating accommodations for obesity

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



| | |
|--------------------|------|
| Physician initials | Date |
|--------------------|------|
