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; 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

○ Female ○ Male

E-mail

Contact number

Address

Town/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

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, may speak on patient's behalf for follow up questions and may be provided details regarding patient's on board accommodation.

Name

Relationship

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

Contact number *(if different than patient's)*

WESTJET

Patient name

PREVIOUS TRAVEL HISTORY

Have you ever flown on a commercial aircraft in the medical condition 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?	○ No	○ Yes

If yes, please provide date and details.

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).

Physicians are required to complete mandatory section 4, initial and date all pages where indicated.
Please select the applicable statement for your patient and complete as directed.

My patient is requesting:

- ☐ Confirmation they are medically fit to fly, an allergy buffer zone, or a seating accommodation ..... *Complete section 1*
- ☐ An extra seat for obesity ..... *Complete sections 1 and 2*
- ☐ A personal attendant ..... *Complete sections 1 and 3*
- ☐ An accommodation inflight to or from the United States ..... *Complete section 4*

Section 4 is mandatory.

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 onboard accommodations are required.

Diagnosis

Date of onset MM/DD/YYYY

Current symptoms and severity

Treatment/prescribed medication(s)

Recent, relevant or planned surgery/sedation ○ No ○ Yes

Nature

Date MM/DD/YYYY

Currently hospitalized? ○ No ○ Yes

If yes, will be discharged to ○ Home ○ Facility

Date of discharge MM/DD/YYYY

Allergies

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

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

Allergen	Symptom	Allergen	Symptom
	☐ Hives ☐ Sneezing ☐ Anaphylaxis ☐ Asthma attack		☐ Hives ☐ Sneezing ☐ Anaphylaxis ☐ 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 Pulse setting ☐ Room air

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

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, please see westjet.com/oxygen for documentation requirements and restrictions. Patient supplied gaseous oxygen cylinders are prohibited on board all WestJet operated flights. WestJet does not supply oxygen for purchase on board 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. Myocardial infarction

○ 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

Details

D. Syncope

○ No ○ Yes

Last episode MM/DD/YYYY

Investigations ○ No ○ Yes ○ Undiagnosed

If investigated, result/cause

Physician initials

Date

WESTJET

Patient name

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 3 if an attendant would mitigate patient's condition during flight.

Seating accommodations

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

Please indicate the seating accommodation and provide medical rational to support.

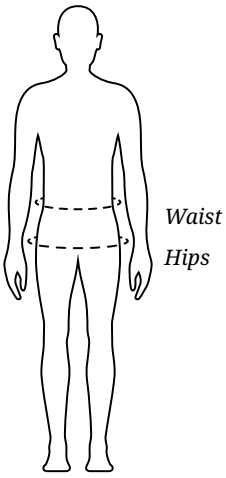
Physician initials

Date

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



SECTION 3: ASSISTANCE REQUIREMENTS

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

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

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

Physician initials

Date

Wheelchairs, transfers and medical equipment

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

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

Will your patient require a wheelchair for

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

Can your patient ascend/descend steps? ○ No ○ Yes

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?

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

Additional Medical Information

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

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

Patient name

SECTION 4: MANDATORY FOR ALL PATIENTS

If your patient consents to providing WestJet with additional medical information, we strongly recommend you complete section 1. This information may help identify further onboard accommodations that may be required to ensure a safe flight.

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 equipment during flight

Is your patient fit to fly? ○ No ○ Yes

Fused or immobilized lower limb

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.

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 their travel? ○ No ○ Yes

Explain

Physician initials

Date

WESTJET

Patient name

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 *(Physician/Practitioner)*

Date MM/DD/YYYY

Physician office stamp required