MEDA HANDLING FORM

FORM NO. 004-2012

PART 1 INCAPACITATED HANDLING FORM

TO BE COMPLETED BY PASSENGER OR SALES AGENT

A PASSENGER INFORMATION	PASSENGER'S NAME:					
	ADDRESS:					
	CONTACT NUMBER/S:					
B FLIGHT ITINERARY	ORIGIN	DESTINATION	AIRLINE CODE	FLIGHT NO.	DEPARTURE DATE	STATUS
C NATURE OF INCAPACITATION	Medical Clearance required? ☐ YES ☐ NO					
	Latest Medical Certificate must be attached to this form Visually Impaired (Blind) and or deaf passengers, must travel with the assistance of a personal able bodied helper, and or escorted by a Trained Dog.					
D ESCORT INFORMATION	COMPLETE NAME:				AGE:	
	ADDRESS:					
	RELATION TO PASSENGER:			CONTACT NUMBER/S:		
E SPECIAL REQUEST	Wheelchair needed? ☐ YES ☐ NO		*Special wheelchair category:*			

IMPORTANT REMINDER
Medical Certificate must be attached and must be submitted to the airline ticket office before ticket issuance and check in counter.
Validity of Medical Form (MEDA) for DOMESTIC FLIGHTS is three (3) days from the date of issue.
Travel date must fall within the validity period.
Fees, if any are to be paid by the passenger.

PART 2 TO BE COMPLETED BY THE PERSONAL PHYSICIAN

MEDA 1	PATIENT'S FULL NAME:	
	ADDRESS:	
	CONTACT NUMBER/S:	
MEDA 2	ATTENDING PHYSICIAN:	
	ADDRESS:	
	CONTACT NUMBER/S:	
MEDA 3	**MEDICAL DATA**	DIAGNOSIS IN DETAILS
		DATE OF FIRST SYMPTOMS
		DATE OF DIAGNOSIS
MEDA 4	**PROGNOSIS FOR THE TRIP**	
MEDA 5	CONTAGIOUS AND COMMUNICABLE DISEASE?	
	WILL IT BE A SOURCE OF DISCOMFORT TO OTHERS? (APPEARANCE, ODOR)	
MEDA 6	CAN PATIENT SEAT IN NORMAL OR AN UPRIGHT POSITION?	
	CAN PATIENT TAKE CARE OF HIS OWN NEEDS ABOARD THE AIRCRAFT?	
MEDA 7	DOES PATIENT NEED ANY MEDICATION ON-BOARD AND OR ON THE GROUND WHILE AT THE AIRPORT?	
MEDA 8	DOES PATIENT NEED ANY **OXYGEN** OR SPECIAL EQUIPMENTS IN FLIGHT?	
MEDA 9	OTHER REMARKS, RELEVANT INFORMATION OR REQUIREMENTS MADE BY ATTENDING PHYSICIAN.	

I authorized (Physician's Name) ______________________________ to provide the airlines with the complete information required by the airline's medical department for the purpose of determining the suitability of my health condition for air travel. I am prepared at my own risk to bear all consequences which the carriage by air may have for my state of health.

Attending Physician Name & Signature	License Number	Date / Place

PASSENGER'S DECLARATION

I, ______________________________, of legal age, and residing at ______________________________ hereby manifest and claim that my travel will be subject to the airline's general conditions of carriage/tariff. I release and hold Magnum .Air (Skyjetair) Inc., its officers, employees and agents harmless from any claim or liability in law or equity. I agree to reimburse the carrier upon demand for any special expenditures or cost in connection with my carriage. I have read and fully understood every word of it and its meaning and voluntarily affixed my signature with the full and complete knowledge of the meaning and intent of this document and of my rights under existing law.

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Passenger's Signature over Printed Name