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		
	☐ Female	☐ Male	☐ 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?	☐ No	☐ Yes
Have you suffered from any medical complications that required medical intervention during a commercial flight?	☐ No	☐ 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

WESTJET

Patient name

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?			☐ No	☐ Yes	
Anemia	☐ No	☐ Yes	If yes, indicate hemoglobin	g/L	Date
Requires an attendant	☐ No	☐ Yes	If yes, complete section 1		
Requires an extra seat for obesity	☐ No	☐ Yes	If yes, complete section 1 and 2		
Severe allergies requiring a buffer zone on board	☐ No	☐ 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?			☐ No	☐ 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?			☐ No	☐ 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

Physician initials	Date

WESTJET

Patient name

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	☐ No	☐ Yes
Nature of hospitalization procedure, surgery or sedation	Date MM/DD/YYYY	
Currently hospitalized?	☐ No	☐ Yes
If yes, will be discharged to	☐ Home	☐ 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
	☐ Hives		☐ Hives
	☐ Sneezing		☐ Sneezing
	☐ Anaphylaxis		☐ Anaphylaxis
	☐ Asthma attack		☐ 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 ☐ 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?	☐ No	☐ Yes
Is oxygen or suction required to manage the seizure?	☐ No	☐ 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?	☐ No	☐ Yes

If yes, please explain

Is your patient alert and oriented x3 to person, place and time?	☐ No	☐ 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?	☐ No	☐ Yes
Can your patient stand, pivot and weight bear?	☐ No	☐ 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?		☐ 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

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

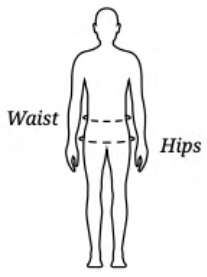
Outline objective medical rationale including your patients medical limitations and restrictions that prevents them from traveling independently once on-board the aircraft

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