

Medical Release and POC Form

Part 1: To be completed by passenger or representative

Name:	Male/Female:
Email:	Telephone:
Itinerary: Flight Number & Date _____ or Booking Reference: _____	

Nature of Incapacitation:
Name of Travel Companion or if Escort (doctor or nurse, please specify):

Mobility Assistance	No <input type="checkbox"/>	Yes <input type="checkbox"/>		No <input type="checkbox"/>	Yes <input type="checkbox"/>
<u>Wheelchair Requested:</u>			<u>Taking your own wheelchair?</u>		
To/From aircraft	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Collapsible	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Help with stairs	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Power Driven	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Immobile:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Spillable battery	No <input type="checkbox"/>	Yes <input type="checkbox"/>
			Weight (lbs.): _____	Dimensions (in's): _____	

Medical Equipment:		
Are you taking any medical equipment with you on board?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If yes, please specify the type of equipment including make and model: _____		
If yes, do you need to use it during the flight?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Can the equipment be switched off during takeoff/landing?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you have sufficient batteries for the duration of the flight?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Hospitalization		
Have you been admitted to hospital within the last four weeks?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Date of admission: _____ Date of discharge: _____		
Is hospitalization required upon arrival?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If yes, please specify name of hospital and contact information: _____		

Passenger's Declaration:	
I hereby authorize _____ (name of doctor) to provide the required medical information and I agree to pay any associated fees.	
_____ Date	_____ Passenger's signature (or representative):



Part 2: To be completed by attending physician**Patient's Name:****Age:****Attending Physician:**

Name: _____

Address: _____

Telephone: _____

Email: _____

Medical Diagnosis: _____**Fit for Travel?**No ☐Yes ☐**Contagious and Communicable Disease?**No ☐Yes ☐**Seating:**

Can patient use normal aircraft seat with seat placed in upright position as required.

No ☐Yes ☐

Can patient bend leg at the knee?

No ☐Yes ☐**Oxygen (POC):**

I certify that _____ requires the use of supplementary oxygen while travelling and this can be met through the use of their FAA, UKCAA, EASA, or Transport Canada approved portable oxygen concentrator (POC).

The oxygen flow rate setting for the POC is _____ liters per minute (LPM), considering the air pressure in the cabin under Operating conditions.

Please select one of the following:

- ☐ POC is medically necessary during all phases of the flight, including taxi, takeoff, and landing.
- ☐ POC is medically necessary only during the portion of the flight when common electronic devices are authorized by crew, which is generally after takeoff and before landing
- ☐ POC is medically necessary intermittently during flight, but not during taxi, takeoff, or landing.

Cayman Airway Ltd., does not offer supplemental airline supplied oxygen for medical use by a passenger.

Physician's signature:**Date and Place:**

X

All questions must be answered and form sent via email to GCMRESSupervisors@caymanairways.net, at least 48 hours before departure. If the form is incomplete, or has not been received within sufficient time to process request, the passenger may be denied boarding. Form must be presented to the agent at the time of check-in.

