

PART 1: INCAD / Incapacitated Passengers Handling Advice

To be completed by Sales Office/Agent. Answer all questions. Mark the respective boxes with a cross.
Please use BLOCK LETTERS when completing this form.

A Name (initials, title) _____

Address _____

Phone _____

B Proposed routing, flight number(s), class, date(s), reservation status, PNR _____

C Nature of incapacity _____

D Is stretcher needed on board (all stretcher cases must be escorted)? Request rate if unknown

No Yes

E Intended escort (name, sex, age, professional qualification)

If untrained, state 'travel companion'. For blind and/or deaf, state if escorted by trained dog

F Wheelchair needed?

No Yes

► Wheelchair categories

WCHR Pax able to ascend/descend a/c steps

WCHS Pax unable to ascend/descend a/c steps

WCHC Pax completely immobile

*for wheelchairs with spillable batteries,

special restrictions imposed by airlines

or countries apply

► Own
wheelchair

No

Yes

Collapsible

No

Yes

Power
driven

No

Yes

Spillable
battery*

No

Yes

G Ambulance needed?

No Yes

► To be arranged by airline

No

► Specify ambulance company contract

Yes

► Specify destination address

H Other ground arrangements needed? Specify for each item a) the arranging airline or other organization b) at whose expenses and c) contact address/phone, where appropriate of specific persons/organizations designated to meet/assist the passenger

1. Arrangements for delivery at airport of departure

2. Arrangements for assistance at connecting points

3. Arrangements for meeting at airport of arrival

4. Other requirements or relevant information

K Special in-flight arrangements needed (such as: special meals, special seating, leg rest, extra seat(s), special equipment, etc. see note at the end of part 2 overleaf)?

No Yes

► Specify for each item a) segment(s) on which required b) airline arranged or arranging third party and c) at whose expense. Provision of special equipment such as oxygen etc. always requires completion of part 2 overleaf

Passenger's declaration

(to be completed for interline travel or at the Swiss International Air Lines Ltd. request)

"I hereby authorize _____ (name of designated physician)

to provide the airlines with the information required by those airlines' medical departments for the purpose of determining my fitness for carriage by air, and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith. I take note that, if I am accepted for carriage, my journey will be subject to the general conditions of carriage/tariffs of the carrier concerned and that the carrier does not assume any special liability exceeding those conditions/tariffs. I am prepared, at my own risk, to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from any liability for such consequences. I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage." (Where needed, to be read by/to passenger, dated and signed by him/her or on his/her behalf).

Place _____

Date _____

Passenger's signature _____

PART 2: MEDIF / Medical Information Sheet

To be completed by attending physician.

This form is intended to provide confidential information, to enable the airline's Medical Department to assess the fitness of the passenger to travel as indicated in Part 1 hereof. If the passenger is acceptable, this information will permit the issuance of the necessary directives designed to provide for the passenger's welfare and comfort. The physician attending the incapacitated passenger is requested to answer all questions. Enter a cross (X) in the appropriate 'yes' or 'no' boxes, and/or give precise answers. Please use BLOCK LETTERS when completing this form. Fill in this form in English, German, French or Italian.

Please return the completed form to (address of issuing Swiss International Air Lines Office)

Confidential

MEDA 1 Patient's name, initials, sex, age

MEDA 2 Attending physician's name, address

Phone numbers
Business

Home

MEDA 3 Medical data: diagnosis in details (including vital signs)

Day/month/year of first symptoms

Date of diagnosis

MEDA 4 Prognosis for the trip

MEDA 5 Contagious and communicable disease?
 No Yes ► Specify

MEDA 6

MEDA 7 Can patient use normal aircraft seat with seatback placed in upright position when so required?
 No Yes

MEDA 8 Can patient take care of his own needs on board unassisted* (including meals, visit to toilet, etc.)?
 No* Yes * If not, type of help needed

MEDA 9 If to be escorted, is the arrangement proposed in PART 1/E hereof satisfactory for you?
 No* Yes * If not, type of escort proposed by you

MEDA 10 Does patient need oxygen equipment** in flight? (if yes, state rate of flow)
 No* Yes ► Litres per minute 2l 4l Continuous? No Yes

MEDA 11 Does patient need any medication* other than self administration, and/or the use of special apparatus such as respirator, incubator, etc.**?
a) on the ground while at the airport(s) No Yes ► Specify

MEDA 12 b) on board the aircraft No Yes ► Specify

MEDA 13 Does patient need any hospitalization? If yes, indicate arrangements made or, if none were made, indicate 'No action taken'
a) during long layover or night stop at connecting points en route
 No Yes ► Action

MEDA 14 b) upon arrival at destination
 No Yes ► Action

MEDA 15 Other remarks or information in the interest of the smooth and comfortable transportation of your patient

MEDA 16 Other arrangements made by the attending physician

* Note: Cabin Attendants are not authorized to give special assistance to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in first aid and are not permitted to administer any injection, or to give medication.

* * Important: fees, if any, relevant to the provision of the above information and for special equipment provided by the carrier, are to be paid by the passenger concerned.

Place

Date

Attending physician's signature