



INDEMNITY: EXPECTANT MOTHERS

Please complete the form below in block letters:

Name of Passenger:

Age:

Address:

Contact Number:

Pregnancy Age:

Months: _ ____

Weeks: _____

Days: _____

TO BE COMPLETED BY EXPECTANT MOTHER

I, the undersigned, hereby state that as of the date hereof, the age of my pregnancy is as set out above and does not exceed 34 weeks hereinafter referred as “*expectant mother/ Passenger*”. I do not suffer from any abnormality connected with my current pregnancy. I hereby take full responsibility for any error or misrepresentation contained above, whether intentional or otherwise.

I hereby indemnify Precision Air Plc and its subsidiary companies (if any), staff members and agents from any liability arising out of any injury, aggravation, deterioration in health suffered either by myself or by my unborn child. I understand and acknowledge fully that:

1. No mother whose pregnancy exceeds 34 weeks on the date of travel is allowed to travel on a Precision Air flight; and that
2. Any mother whose pregnancy exceeds 24 weeks is required to submit a Medical Certificate filled within confirming her fitness to travel on a Precision Air flight.
3. Notwithstanding the aforementioned provisions of this indemnity Agreement, Upon knowledge, Precision Air reserves the right to deny boarding/offload any expectant mother who does not meet the requirements on the date of travelling (on originating, transit or return flight) irrespective of the date of purchasing the ticket, consulting medical practitioners and/or any error(s) that may have occurred at any stage
4. I am conversant with a detailed expectant mother policy as made available on www.precisionairtz.com and Precision Air offices.

I understand that Precision Air does not guarantee availability of medical personnel on its flights to attend to me or my unborn child and consent to the risks that may be associated therewith.

I warrant that I have read and understood the above and that by virtue of that understanding; I voluntarily agree to be bound thereto upon appending my signature below.

SIGNED AT _ _ _ **ON THIS** _ _ **DAY OF** _ _ _ _

Signature of Passenger

PRECISION AIR Services PLC

MEDICAL INFORMATION SHEET - MEDIF

To be completed by ATTENDING PHYSICIAN

This form is intended to provide CONFIDENTIAL information to enable the airlines' Customer Service Section to assess the Fitness of the passenger to travel. If the passenger is acceptable this information shall permit the issuance of the necessary directives designed to provide for the passengers' 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 concise answers).

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

This form shall be returned to the Station Manager

PW MEDA01	PATIENTS NAME	SEX,	AGE
-----------	---------------	------	-----

MEDA02	<p>RELEVANT MEDICAL HISTORY</p> <hr/> <hr/> <hr/> <hr/> <hr/> <p>DETAILED DIAGNOSIS</p> <hr/> <hr/> <hr/> <hr/> <hr/> <p>CURRENT CLINICAL STATUS</p> <hr/> <hr/> <hr/> <hr/> <hr/>		
MEDA03	RECENT SURGICAL HISTORY	DIAGNOSIS/REASON FOR SURGERY. <hr/> DATE SURGERY DONE	
MEDA04	PROGNOSIS under reduced atmospheric and Oxygen pressure at the flight altitude.		
MEDA05	Any Contagious AND communicable diseases?	NO	Yes Specify

MEDA06	-Would the physical and /or mental condition of the patient cause Distress or discomfort to other passengers?		No	Yes Specify	
MEDA07	Can patient use normal aircraft seat with seat back placed in upright position when so required?		NO Specify		YES
MEDA08	Can patient take care of his own needs on board UNASSISTED* (Including meals, visit to toilet, etc)?		YES		NO
	If not, indicate the kind of help needed				
MEDA09	According to your evaluation,		Yes		Medical escort
	Does the passenger need a escort?		No		Non Medical escort
EDA010	Does the patient need OXYGEN?	Yes	Stand-by Oxygen	Continuous Flow Oxygen	If continuous, what is the rate in liters/Min. _____ _____
		No			
Does the patient need medical equipment in flight					Yes

	Type of equipment	Powered	Battery powered?	Voltage of _____ Volts
		Manual	Electrical power source? DC / AC	
MEDA011	Does patient need any MEDICATION during the flight? YES NO		If yes, indicate type of medicine and instructions. 1. 4. _____ 2. _____ 5. _____ 3 _____ 6. _____	
MEDA012	a) Does patient need hospitalization during long layover night stop at CONNECTING POINTS en route? NO ___ YES ___ Have any arrangement been made for that ? Yes ___ No ___ b) Any arrangement made for an ambulance to pick up the passenger? Yes ___ No ___			
MEDA013	Please indicate any other information necessary for the patient's smooth and comfortable flight. _____ _____ _____ _____ _____			
MEDA014	Other arrangements made by the attending physician:			
NOTE. Cabin attendants are NOT authorized to give extraneous services (e.g. lifting) to particular passengers, to the detriment of service to other		IMPORTANT: Any fees that is payable in respect of the provision of the above information and any special equipment provided by the airline is		

passengers.
Additionally, they are trained only in FIRST AID
and are NOT PERMITTED to administer or give
any medication.

payable by the passenger concerned.

The name of hospital / Practice _____

Tel: _____

Official Stamp _____