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MEDICAL INFORMATION FORM (MEDIF) 【To be completed by the attending physician】

The attending physician is requested to answer all questions. Enter a check mark(✓) in the appropriate "Yes" or "No" boxes, and/or give precise and concise answers. Please send the Medical Information Form by fax to +81-50-3737-9665 and call us at least 5 business days prior to your departure.

PATIENTS INFORMATION

Name		Age	
		Gender	☐ male ☐ female
Diagnosis in details	*Please write so that non medical personnel can understand.		
When did the first symptoms appear (Date of Operations, if any)	Date:	For expecting mother (Estimated delivery date)	Date:

DIAGNOSIS CONTENT

1	Prognosis for the flight(s)	☐ Fit ☐ Not Fit	Prognosis for the Return Flight (if any) Date of return flight	☐ Fit ☐ Not Fit
2	Can the patient use normal aircraft seat with the seatback placed in the Upright Position when so required? (during take-off and landing)	☐ Yes ☐ No		
3	Can the patient is fully capable/able to use lavatory, provide self-care (eat, drink…etc.) unattended without assistant from flight crew?	☐ Yes ➔ *The patient must be fully knowledgeable in its use. ☐ No, Must be accompanied by Physician or Nurse ☐ No, Must be accompanied by a person who is approved by Physician		
4	Dose passenger need Oxygen equipment in flight?	☐ Yes ➔ If "Yes", Liters per minute : ☐ (ℓ/min) ☐ No		
	Continuous use?	☐ Yes ☐ No		
5	Dose the patient need medical equipment in flight?	☐ Yes ➔ <The Name of Medical Equipment> ☐ No <Manufacturer or Distributor> <Product name / type or model number> <Size / Type of Battery>		
6	Does patient need any medication in flight?	☐ Yes ➔ Specify: ☐ No		
7	Specify more details, if necessary			

Prognosis as above. I will provide necessary information required by the airline's for the purpose of determining his/her fitness to travel by air with consent of the patient.

PHYSICIAN			Date of Submission:
NAME (Signature)			
Hospital Name			
Telephone Number		Emergency Telephone Number	

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SPECIAL ASSISTANCE REQUEST 【To be completed by the passenger or travel agent】

PATIENTS INFORMATION

Name		Age	
		Gender	☐ male ☐ female
Telephone Number	(Home)	(Mobile)	
E-mail Address			
Itinerary	1. Date: Flight No.:	Travel segment(DEP-ARR): (—)	
	2. Date: Flight No.:	Travel segment(DEP-ARR): (—)	
Personal Escort	Name:	☐ Pysician ☐ Nurse ☐ Others (	
Personal Escort	Name:	☐ Pysician ☐ Nurse ☐ Others (	

1 Do you need wheelchair? ☐ No ☐ Yes → Please let us know your mobility condition in order for us to accommodate your needs.
- ☐ Unable to walk, require wheelchair at all time
- ☐ Able to walk but require assistant ascend or descend steps
- ☐ Able ascend or descend steps by own accord but unable walk long distance

2 Please tell us about your personal mobility assistant device, wheelchair.
- ☐ No wheelchair
- ☐ Personal wheelcha → ☐ Manual → ☐ Foldable / ☐ Non-foldable
- ☐ Electric/Battery-powered → ☐ Non-Spillable Battery (Wet-cell “sealed”) / ☐ Dry Battery (NiCad, Ni-MH) / ☐ Li-ion Battery

*Please send "Wheelchair Check Form" if you require wheelchair assistant.
*Peach Aviation do not accept Battery-powered wheelchair with Spillable Battery (Wet-cell “non-sealed”).

3	Do you require wheelchair in cabin	☐ No	☐ Yes	
4	Do you require Oxygen Cylinder in flight?	☐ No	☐ Yes	➔If yes,plese send "Oxygen Cylinder Check Form".
5	Do you use Portable Oxygen Concentrator in flight?	☐ No	☐ Yes	➔If yes,plese send "Portable Oxygen Concentrator Check Form".

Agreement

I here by authorize _____(Name of nominated attending physician) to provide the airlines with the information, required by those airline's medical department 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 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 agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.

Date: _____ Passengers signature: _____
(or a Representative)

CC-012-002