Fit To Fly Health Certificate

Name:		
Date of birth:(dd/mm/yyyy)	Age: y/o	Sex:
No. of passport:		
Date of Examination:	Time:	

To Whom It May Concern :
This is to certify that above name's patient has been examined.

Diagnosis : _____

Travel Recommendation and Assessment (Please tick in the box):
☐ Fit to fly as normal seated passenger
☐ Fit to fly with medical escort(s) only
☐ Fit to fly with non-medical escort/family
☐ Not fit to fly/Travel only at patient's own risk

Special requirement(s), (Please tick in the box):
☐ None
☐ Economy class ☐ Business class ☐ First class Stretcher
☐ Wheelchair ☐ to Step ☐ to Ramp to Seat(Cabin) ☐ Oxygen supply
☐ Others (Please specify)
_____
_____

I understand the risk(s) involved in air travel and accept full responsibility for myself.
Signature, Patient : _____

Full name(Block letters) : _____

Date of Issue : _____

Signature of Physician : _____
Name of Physician : _____

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