الـيوبيل الذهبي
1950
Golden
Jubilee

APPLICATION FOR THE CARRIAGE OF MEDICAL PASSENGER

Answer ALL questions (delete as applicable)

STRETCHER CASE, SITTING CASE or INCUBATOR and/whether REQUIRING OXYGEN

PASSENGER/FLIGHT DETAILS

1. PASSENGER'S NAME ....FAMILY NAME/OTHER NAMES

   PERMANENT ADDRESS

   TELEPHONE NUMBER

2. FLIGHT REQUESTED GF .... DATE .... FROM .... TO ....

3. I, ... HEREBY INDEMNIFY AND HOLD GULF AIR HARMLESS FROM AND AGAINST ANY LIABILITY ARISING OUT OF ANY BODY INJURY AND/OR DEATH, DAMAGE OR LOSS I MAY SUFFER AND FROM AND AGAINST ANY OTHER DAMAGE, PAYMENTS, EXPENSES, FEES AND COSTS WHICH GULF AIR MAY INCUR DIRECTLY OR INDIRECTLY AS A RESULT OF ACCEPTING ME FOR CARRIAGE ON ITS FLIGHT, AND I DO HEREBY UNDERTAKE TO REPAY GULF AIR THE SAME DAMAGES, PAYMENTS, EXPENSES, FEES AND COSTS.

   I ALSO UNDERSTAND AND AGREE THAT ANY SUCH PAYMENTS, EXPENSES, FEES AND COSTS MADE OR INCURRED BY GULF AIR SHALL BE SOLELY FOR MY WELFARE AND WILL BE WITHOUT PREJUDICE AND EXTREMELY WITHOUT ADMISSION OF ANY LIABILITY ON THE PART OF GULF AIR.

   THE ATTENDANT IS TO ENSURE THAT ALL ITEMS OR MEDICAL EQUIPMENT BROUGHT ONTO THE AIRCRAFT WITH THE PATIENT (INCLUDING NEEDLESS, SYRINGES AND UNUSED MEDICATIONS) ARE REMOVED AT THE TIME THE PATIENT IS DISEMBARKED FROM THE AIRCRAFT."

SIGNATURE ....
OF PASSENGER

MEDICAL DETAILS

Please ensure that you read note 10 overleaf
(COMPILED BY PASSENGERS DOCTOR - TYPED OR IN BLOCK CAPITALS

4. PASSENGER'S DOCTOR ....TEL. NO. ....
5. PATIENT: MALE/FEMALE (delete as applicable) AGE .... DATE OF ONSET OF ILLNESS ....
6. HEIGHT ................................CM...WEIGHT...KG
7. DIAGNOSIS ....
8. Is the disease contagious or infectious in any form? YES/NO (delete as applicable) if so, how ?

   ....
9. PRESENT SYMPTOMS ....

   ....
10. PROGNOSIS ....

    ....
11. a. BP .... b. HB.................................... c. Dyspnosa Nil/Mild/Savara (delete as applicable)
12. Give details of any drug therapy ....
13. State requirements for special treatment and/or Oxygen. (oxygen flow rate in litre per minute..................................)

    a. In flight.. b. At ground stops ....
14. Does patient have full control of Bowels/Bladder? YES/NO (delete as applicable)
15. Can patient eat/drink unaided? YES/NO (delete as applicable)
16. Can patient use the aircraft toilet unaided ? YES/NO (delete as applicable)
17. Does patient require a wheelchair? YES/NO (delete as applicable)

    If yes, which of the following ? a. aircraft steps b. to the cabin door c. to the seat (delete as applicable)
18. Does patient require Doctor/Qualified Nurse/Non Medical Escon ? YES/NO (delete as applicable)
19. Is patient accompanied? If so, by whom ?
20. Details of Ambulance/Hospitalisation arrangements at destination, if necessary.

    a: Ambulance supplier (i). At embarkation ....

    Hospital (ii) At destination ....

    Whether confirmation given to passenger with reference ....
21. Above details completed by Dr. ....Date ....Signature ....

GF-2124 (FEB. 2000)
S/C 3385424

DISTRIBUTION:

WHITE	: GULF AIR MEDICAL CENTRE BAHRAIN
YELLOW	: PASSENGER
GREEN	: CAPTAIN GULF AIR AIRCRAFT CARRYING PASSENGER
PINK	: STATION FILE AT DEPARTURE STATION