Thomsonfly.com

MEDICAL CLEARANCE REQUEST FORM

MEDICAL COMPANY :
CONTACT NAME :
TELEPHONE NUMBER :
FAX NUMBER :
DATE :

PATIENT'S NAME : **AGE :**

INBOUND FLIGHT NUMBER : **DATE :**

ROUTE :

TOUR OPERATOR : **REFERENCE NO :**

EXTRA SEATS PURCHASED :

ILLNESS / INJURY :

DATE OF ONSET :

ACCOMPANIED BY :

DOCTOR ESCORT :

NURSE ESCORT :

STRETCHER REQUIRED :

OXYGEN REQUIRED: YES/NO IF YES RATE OF FLOW:-

W'CHAIR ASSIST (WCHR / WCHS / WCHP / WCHC) :

ATTENDING DOCTOR: **TEL NO :**

ON ARRIVAL CLIENT WILL BE MET BY :

CLIENTS ORIGINAL FLIGHT DETAILS:
TOUR OPERATOR / REFERENCE NO :
OUTBOUND DETAILS :
INBOUND DETAILS :

ADDITIONAL INFO:

PAX WILL HAVE FIT TO FLY CERTIFICATE

RETURN TO : PASSENGER SERVICES DEPARTMENT
FAX NO: 01582 428846 TEL NO: 0870 607 6757