

To be completed by PASSENGER / TRAVEL OFFICE / ATTENDING PHYSICIAN In accordance with IATA Resolution 700 Attachment A, 29<sup>th</sup> Edition June 2009

**A** **NAME**, Initials, Title \_\_\_\_\_  
 Address, Phone \_\_\_\_\_  
 \_\_\_\_\_

**B** Proposed **ITINERARY** Routing, flight number(s), Class, date(s), reservation status \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Transfer from one flight to another often requires longer connecting time.

**C** **NATURE OF INCAPACITY** \_\_\_\_\_  
 \_\_\_\_\_

**D** Is **STRETCHER** needed on board? (All stretcher cases must be escorted) No  Yes

**E** Intended **ESCORT** (Name, sex, age, professional qualification, routing if different from passenger). If untrained, state "TRAVEL COMPANION" \_\_\_\_\_  
 \_\_\_\_\_

**F** **WHEELCHAIR** needed? No  Yes  Wheelchair Categories:  WCHR–Pax able } To ascend } OWN } Collaps- } Power } Spillable } For wheelchairs with  
 WCHC–Pax unable } descend } Wheelchair } ible } driven } battery } spillable batteries,  
 WCHC–Pax completely immobile Yes  No  No  No  No  special restrictions  
 a/c steps No  Yes  Yes  Yes  Yes  imposed by airlines  
 or countries apply.

**G** **AMBULANCE** needed? No  Yes  To be organized by assistance/insurance/passenger  
 No  specify Ambulance Company contact: \_\_\_\_\_  
 Yes  specific destination address: \_\_\_\_\_

**H** **OTHER GROUND ARRANGEMENTS** needed? SPECIFY for each item: a) the arranging airline or other organisation, b) at whose expenses and c) contact addresses/phone where appropriate, of specific persons/organisations designated to meet/assist the passenger.

**1** Arrangements for delivery at airport of departure: \_\_\_\_\_  
**2** Arrangements for assistance at connecting points: \_\_\_\_\_  
**3** Arrangements for meeting at airport of arrival: \_\_\_\_\_  
**4** Other requirements or relevant information: \_\_\_\_\_

**K** **SPECIAL IN-FLIGHT ARRANGEMENTS** needed such as: special meals, special seating, leg-rest, extra seat(s), special equipment, etc. No  Yes  SPECIFY for each item: a) segment(s) on which required, b) airline-arranged or arranging third party and c) at whose expense. Provision of special equipment such as oxygen etc. always requires completion of MEDIF.  
 \_\_\_\_\_  
 \_\_\_\_\_

**L** Does passenger hold a **FREMEC** (Frequent Traveller's Medical Card) valid for this trip? No  Yes  If additional data needed by carrying airline(s), have physician in attendance complete the MEDIF.  
 Add below FREMEC data to your reservation requests.  
 \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Incapacity \_\_\_\_\_  
 FREMEC Number \_\_\_\_\_ Issued by \_\_\_\_\_ Valid until \_\_\_\_\_ Limitations \_\_\_\_\_

**PASSENGER'S DECLARATION** (To be completed for interline travel or at **CROATIA AIRLINES** request)  
 "I hereby authorize \_\_\_\_\_ (name of designated physician) to provide the airlines with the information required by those airlines' medical departments 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 am prepared, at my own risk, to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from any liability for such consequences.  
 I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.  
 (Where needed, to be read by/to the passenger, dated and signed by him/her or on his/her behalf.)

Place: \_\_\_\_\_ Date: \_\_\_\_\_ Passenger's Signature \_\_\_\_\_

|  |   |  |
|--|---|--|
| To be completed by<br>ATTENDING<br>PHYSICIAN | The form is intended to provide confidential information, to enable the airlines' Medical Department to assess the fitness of the passenger to travel as indicated in Part 1 hereof. If the passenger is acceptable, this information will permit the issuance of the necessary directives to provide for the passenger's welfare and comfort. The physician attending the incapacitated passenger is requested to answer all questions.<br>Enter a cross (x) in the appropriate "yes" or "no" boxes, and/or give precise answers. Use block letters when completing this form. | Decision of Croatia Airlines doctor:<br><br>Please return the completed form to:<br><br>(Address of issuing Croatia Airlines office) |
|--|---|--|

|                |   |  |                              |  |
|----------------|---|--|------------------------------|--|
| <b>MEDA 01</b> | Airlines Ref. Code  | Patient's Name, Initials, Sex, Age   |                              |  |
| <b>MEDA 02</b> | Attending Physician's Name, Address   | Phone numbers:   | Business:                    | Home:  |
| <b>MEDA 03</b> | <b>MEDICAL DATA:</b><br>Diagnosis in details (including vital signs)  | Day/ month/ year of first symptoms:  |                              | Date of diagnosis:   |
| <b>MEDA 04</b> | Prognosis for the trip:   |  |                              |  |
| <b>MEDA 05</b> | Contagious and communicable disease?  | No <input type="checkbox"/>  | Yes <input type="checkbox"/> | Specify: _____   |
| <b>MEDA 06</b> | Is patient in any way <u>offensive</u> to other passengers?   | No <input type="checkbox"/>  | Yes <input type="checkbox"/> | Specify: _____   |
| <b>MEDA 07</b> | Can patient use normal aircraft seat with seatback placed in <u>upright</u> position when so required?  | Yes <input type="checkbox"/>   | No <input type="checkbox"/>  |  |
| <b>MEDA 08</b> | Can patient take care of his own needs on board <u>unassisted*</u> (including meals, visit to toilet, etc.)?<br>If not, type of help needed _____ | Yes <input type="checkbox"/>   | No <input type="checkbox"/>  |  |
| <b>MEDA 09</b> | If to be <u>escorted</u> , is the arrangement satisfactory to you?<br>If not, type of escort proposed by you _____                                | Yes <input type="checkbox"/>   | No <input type="checkbox"/>  |  |
| <b>MEDA 10</b> | Does patient need <u>oxygen**</u> equipment in flight?<br>(If yes, state rate of flow)  | No <input type="checkbox"/>  | Yes <input type="checkbox"/> | Litres per minute <input style="width:40px;" type="text"/> Continuous: Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| <b>MEDA 11</b> | Does patient need any <u>medication*</u> other than self-administered and/or the use of special apparatus such as respirator, incubator, etc.**?  | a) on the <u>ground</u> while at the airport(s)?<br>No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____                  |                              |  |
| <b>MEDA 12</b> |   | b) on board the <u>aircraft</u> ?<br>No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____                                 |                              |  |
| <b>MEDA 13</b> | Does patient need <u>hospitalisation</u> ?<br>If yes, indicate arrangements made or, if none were made, indicate "NO ACTION TAKEN".               | a) during long layover or nightstop at connecting points en route?<br>No <input type="checkbox"/> Yes <input type="checkbox"/> Action: _____ |                              |  |
| <b>MEDA 14</b> |   | b) upon arrival at destination?<br>No <input type="checkbox"/> Yes <input type="checkbox"/> Action: _____                                    |                              |  |
| <b>MEDA 15</b> | Other remarks or information in the interest of the smooth and comfortable transportation of your patient:  |  |                              |  |
| <b>MEDA 16</b> | Other arrangements made by the attending physician:   |  |                              |  |

\*NOTE: Cabin attendants are not authorized to give special assistance to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in FIRST AID and are NOT PERMITTED to administer any injections, or to give medication.

\*\* IMPORTANT: Fees, if any, relevant to the provision of the above information and for special equipment provided by the carrier, are to be paid by the passenger concerned.

|        |       |                                 |
|--------|-------|---------------------------------|
| Place: | Date: | Attending Physician's Signature |
|--------|-------|---------------------------------|