

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

A	NAME , Initials, Title Address, Phone	_____ _____ _____
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B	Proposed ITINERARY Routing, flight number(s), Class, date(s), reservation status	Transfer from one flight to another often requires longer connecting time.
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C	NATURE OF INCAPACITY
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D	Is STRETCHER needed on board? (All stretcher cases <u>must</u> be escorted)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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E	Intended ESCORT (Name, sex, age, professional qualification, routing if different from passenger). If untrained, state "TRAVEL COMPANION"
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F	WHEELCHAIR needed?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Wheelchair Categories: <input type="checkbox"/> WCHR–Pax able <input type="checkbox"/> WCHC–Pax unable <input type="checkbox"/> WCHC–Pax completely immobile	} To ascend descend a/c steps	OWN Wheelchair No <input type="checkbox"/> Yes <input type="checkbox"/>	Collapsible No <input type="checkbox"/> Yes <input type="checkbox"/>	Power driven No <input type="checkbox"/> Yes <input type="checkbox"/>	Spillable battery No <input type="checkbox"/> Yes <input type="checkbox"/>	For wheelchairs with spillable batteries, special restrictions imposed by airlines or countries apply.
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G	AMBULANCE needed?	No <input type="checkbox"/> Yes <input type="checkbox"/>	To be organized by assistance/insurance/passenger No <input type="checkbox"/> specify Ambulance Company contact: _____ Yes <input type="checkbox"/> specific destination address: _____
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H	OTHER GROUND ARRANGEMENTS needed?	SPECIFY for each item: a) the <u>arranging airline</u> or other organisation, b) at whose <u>expenses</u> and c) <u>contact addresses/phone</u> where appropriate, of specific persons/organisations designated to meet/assist the passenger.
1	Arrangements for delivery at airport of <u>departure</u> :	_____
2	Arrangements for assistance at <u>connecting points</u> :	_____
3	Arrangements for meeting at airport of <u>arrival</u> :	_____
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 <input type="checkbox"/> Yes <input type="checkbox"/>	SPECIFY for each item: a) <u>segment(s)</u> on which required, b) <u>airline-arranged</u> or arranging third party and c) at whose <u>expense</u> . Provision of <u>special equipment</u> such as oxygen etc. always requires completion of MEDIF.
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L	Does passenger hold a FREMEC (Frequent Traveller's Medical Card) <u>valid</u> for this trip?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If additional data needed by carrying airline(s), have physician in attendance complete the MEDIF. Add below FREMEC data to your reservation requests.
FREMEC Number _____ Issued by _____ Valid until _____		Sex _____ Age _____ Incapacity _____ 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
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To be completed by ATTENDING 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. 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: Please return the completed form to: (Address of issuing Croatia Airlines office)
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MEDA 01	Airlines Ref. Code	Patient's Name, Initials, Sex, Age		
MEDA 02	Attending Physician's Name, Address	Phone numbers:	Business:	Home:
MEDA 03	MEDICAL DATA: Diagnosis in details (including vital signs)	Day/ month/ year of first symptoms:		Date of diagnosis:
MEDA 04	Prognosis for the trip:			
MEDA 05	Contagious and communicable disease?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Specify: _____
MEDA 06	Is patient in any way <u>offensive</u> to other passengers?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Specify: _____
MEDA 07	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"/>	
MEDA 08	Can patient take care of his own needs on board <u>unassisted*</u> (including meals, visit to toilet, etc.)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If not, type of help needed _____
MEDA 09	If to be <u>escorted</u> , is the arrangement satisfactory to you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If not, type of escort proposed by you _____
MEDA 10	Does patient need <u>oxygen**</u> equipment in flight? (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"/> No <input type="checkbox"/>
MEDA 11	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)? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____		
MEDA 12		b) on board the <u>aircraft</u> ? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____		
MEDA 13	Does patient need <u>hospitalisation</u> ? 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? No <input type="checkbox"/> Yes <input type="checkbox"/> Action: _____		
MEDA 14		b) upon arrival at destination? No <input type="checkbox"/> Yes <input type="checkbox"/> Action: _____		
MEDA 15	Other remarks or information in the interest of the smooth and comfortable transportation of your patient:			
MEDA 16	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.
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Place:	Date:	Attending Physician's Signature
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