

Fit To Fly Health Certificate

Name:		
Date of birth:	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(dd/mm/yyyy) : / / _____

Signature of Physician : _____

Name of Physician : _____

