



MEDICAL CERTIFICATE OF FITNESS FOR AIR TRAVEL

Flight No. / Date : .....

1. Name of Passenger (Block capitals): .....

2. Age: ..... 3. Address & Phone number: .....

4. Hospital/Clinic (if relevant): ..... Phone No: .....

5. Present symptoms: .....

6. Diagnosis of condition: .....

7. Whether infectious or non infectious? : .....

8. Nature of treatment: .....

9. Can patient walk unaided? .....

10. Can patient travel in sitting position for the duration of the flight?
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11. Whether patient has full control of bowels and bladder? .....

12. Whether patient displays suicidal tendencies or is subject to fits of violence: .....
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13. What extra facilities needed for safety & comfort of Passenger?

Wheelchair: ..... Stretcher: ..... Ambulance: .....

Oxygen- Liters/min & No.- hours: ..... Other: .....

14. Does passenger require: Doctor: Yes / No Nurse: Yes / No Other: .....

15. Cardiac cases: Yes/No -Details: .....

It is certified that in my opinion, the above named is medically fit to travel by air from ..... to
..... and that the patient will not be a nuisance or endanger the lives of other passengers.

Attending Doctor's name: .....Signature: ..... Tel/Fax: .....

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Remarks of Airline Medical Doctor:

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Address: CLINIQUE DARNE Phone No: 601 2300 Fax No: 696 1209

Signature: ..... Date: .../...../.....

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I,.....HEREBY INDEMNIFY AND HOLD AIR MAURITIUS HARMLESS FROM AND AGAINST ANY LIABILITY ARISING OUT OF ANY BODY INJURY AND/OR DEATH, DAMAGE OR LOSS I MAY SUFFER AND AGAINST ANY OTHER DAMAGE, PAYMENTS, OF ACCEPTING ME FOR CARRIAGE ON ITS FLIGHT, AND I DO HEREBY UNDERTAKE TO REPAY AIR MAURITIUS 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 AIR MAURITIUS SHALL BE SOLELY FOR MY WELFARE AND WILL BE WITHOUT PREJUDICE AND ENTIRELY WITHOUT ADMISSION OF ANY LIABILITY ON THE PART OF AIR MAURITIUS.

SIGNATURE OF PASSENGER .....