NACC National Airlines Council of Canada
CNLA Conseil national des lignes aériennes du Canada

AIR CANADA | Air transat | WESTJET

Air Travel Requirements Assessment Form

SUBMISSION GUIDELINES

Before your trip, please submit both sections of this form.

Section 1 - must be completed by you or your parent, guardian, or representative
Section 2 - must be completed by your healthcare provider (i.e., doctor, nurse practitioner or physician assistant)

To help us meet your travel needs, we recommend **submitting this document at least 48 hours prior** to your departure. For requests made with less advance notice, we'll do our best to accommodate your needs.

Please refer to our Medical Approval page for guidelines on when to complete this form.

SECTION 1 – PASSENGER

This section is to be completed by you (the passenger) or your parent, guardian, or representative. Please complete electronically or use CAPITAL LETTERS and black ink.

Passenger Information

First Name	Last Name	Date of Birth (DD/MM/YYYY)
		_ _/_ _/_ _ _ _
Email	Phone	

Parent, Guardian, or Representative Information
If someone is completing this form on your behalf, please have them enter their information in this section.

First Name	Last Name	Relationship to passenger

Email (if different from passenger)	Phone (if different from passenger)	

Prior Flights	
Have you previously taken a commercial flight with your current medical condition and status?	☐ Yes ☐ No
If yes, when? (DD/MM/YYYY)	_ _/_ _/_ _ _ _
Did you require any accommodations? If yes, please explain:	☐ Yes ☐ No
Did you experience any medical problems? If yes, please explain:	☐ Yes ☐ No

About your Support Person
If you're travelling with a support person, please complete this section.

Is your intended support person able to assist you with the following, if required?

- Eating meals, taking medication, and using the washroom
- Transferring you to and from your aircraft seat during flight
- Orientation and communication
- Physical assistance in the event of an emergency, including during an evacuation or decompression

☐ Yes – my support person is able to assist me with all my needs
☐ No – my support person cannot provide all the assistance I need*

*Please ensure your intended support person is prepared and able to provide all the assistance above that you need.

Your intended support person must:

- Be 18 years of age or older
- Not require any assistance from the airline that would prevent them from providing the assistance you may need on board
- Not be responsible for the needs of any other passenger during the flight, including an infant, child, pet or other animal that would prevent them from providing the assistance you may need on board
- Remain with and be seated adjacent to you
- Be fully capable of attending to their own physical and mental care needs during the flight, as well as yours

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

☐ Yes – my support person meets all the criteria above
☐ No – my support person does not meet all the criteria above

Note: Your support person does not need to be medically trained, and they are not required to assist you with placing your carry-on baggage in the overhead bin unless they choose to do so.

Authorization and Consent

The following section must be read by/to the passenger and dated and signed by the passenger, or signed and dated by the parent, guardian, or representative who completed the form on the passenger's behalf.

Please review each item below and indicate your consent by adding your signature and the date you completed this form at the bottom of the following section.

Authorization to Collect, Use and Disclose Information

Consent for Collection, Use, Disclosure, and Retention of Information

I consent to the collection, use, disclosure, and retention of my personal and medical information by the airline's accessibility services team for purposes of facilitating safe travel in accordance with the airline's Privacy Policy. I understand that my information will be kept confidential and may be retained for three (3) years, as per the *Accessible Transportation for Persons with Disabilities Regulations*, to support future service requests. Please review the airline's Privacy Policy for more details.

Consent to Discuss Information with Healthcare Providers and Others

By submitting this form, I consent to the airline discussing and collecting my information with my healthcare provider, family members, or decision-makers if I am unable to provide consent myself to ensure appropriate care and accommodation during travel. I also authorize the airline to share a copy of this authorization and consent with my healthcare provider.

In capital letters, add the first and last name of your dedicated healthcare provider in the space provided.

I hereby authorize _____ to provide the airline with the personal and medical information required by the airline's health professional or health service provider for the purpose of assessing my air travel needs.

Passenger, Parent, Guardian, or Representative's Signature	**Date Signed** (DD/MM/YYYY)
x_____	_ _/_ _/_ _ _ _

Note: If your medical condition/travel details change in any way from those indicated on this form, you are required to contact the airline to indicate the information provided in this form is no longer valid, and you will then need to submit a new form before travelling.

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

SECTION 2 – HEALTHCARE PROVIDER

This section is to be completed by **your dedicated healthcare provider** (doctor, nurse practitioner or physician assistant). Please complete electronically or use CAPITAL LETTERS and black ink.

This form is intended to provide CONFIDENTIAL information to evaluate your patient's medical needs to ensure safe travel and to minimize the risk of any adverse medical event.

As the patient's **designated healthcare provider, you must answer all questions applicable to your patient in the following section.** Enter an "X" in the appropriate "Yes" or "No" box and give concise answers where additional information is required.

Incomplete forms may be returned and could cause a delay in determining acceptance of your patient for air travel.

Patient's Information		
First Name	Last Name	Date of Birth (DD/MM/YYYY) _ _/_ _/_ _ _ _
Healthcare Provider's Information		
First Name	Last Name	Professional Designation
License Number	Province/State of Registration	Country of Registration
Email	Phone	Fax
Diagnosis and Medical Details		
Diagnosis	Medical Details (e.g. type of operation)	

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Medications		
Surgery/Procedure, if applicable (recent, relevant, or planned hospitalization /procedure/surgery/ sedation) Date of Surgery (DD/MM/YYYY) _ _/_ _/_ _ _ _	Recent vital signs HR ___ BP ___ RR ___ Date of Exam (DD/MM/YYYY) _ _/_ _/_ _ _ _	Is the patient's condition stable? ☐ Yes ☐ No Date of Onset (DD/MM/YYYY) _ _/_ _/_ _ _ _
Is the patient currently hospitalized? ☐ Yes ☐ No	If the patient is currently hospitalized, where will they be discharged to? ☐ Home ☐ Facility	Date of Discharge (DD/MM/YYYY) _ _/_ _/_ _ _ _
Other Medical Information		
Does the patient have any other underlying medical conditions? If Yes, please specify:		☐ Yes ☐ No
Does the patient have an infectious communicable disease that could pose a direct threat to the health or safety of others and/or has been advised by public health authorities or their healthcare provider to remain isolated due to contagiousness (e.g. measles, tuberculosis)? If Yes, please specify:		☐ Yes ☐ No

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Has the patient's condition deteriorated recently? If Yes, please describe:	☐ Yes ☐ No

Patient's Prognosis for Flights
(with no extraordinary medical attention)

☐ **Poor Prognosis** Indicated by any of the following (please select): ☐ The patient has an unstable medical condition. ☐ The patient has a medical condition that may worsen in an aircraft (i.e. in a hypoxic environment with up to 30% reduction in ambient partial pressure of oxygen, and with cabin pressure approximately 8,000 ft above sea level). ☐ The patient may require medical assistance or emergency medical equipment during the flight.	☐ **Good Prognosis** The patient's medical condition is stable and will not worsen in an aircraft environment, and the patient will not require medical assistance or emergency medical equipment.

Additional Clinical Information
Please check Yes or No for all conditions listed below. If you check Yes to any, please complete the corresponding section.

Anemia ☐ Yes ☐ No	**If Yes** Recent hemoglobin g/L: __/__ Post-operative hemoglobin g/L (for surgery within 72 hours of flight departure): __/__ Date Taken (DD/MM/YYYY): _ _/_ _/_ _ _ _ Details:
Cardiac Disorders ☐ Yes ☐ No	**If Yes, please fill out the appropriate section(s)** ☐ **Angina** Date of last episode (DD/MM/YYYY): _ _/_ _/_ _ _ _ Is the patient's condition stable? ☐ Yes ☐ No

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

What is the patient's functional status? (Please select)
☐ No symptoms
☐ Angina with moderate exertion
☐ Angina with minimal exertion
☐ Angina at rest

Can the patient walk 50 metres at a normal pace, or climb 10-12 stairs without symptoms?
☐ Yes
☐ No

☐ **Myocardial Infarction**

Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Complications?
☐ Yes
☐ No
If yes, provide details:

Stress ECG Done?
☐ Yes
☐ No

If yes, what was the result?
☐ MET
☐ WATT

If angioplasty or coronary bypass, can the patient walk 100 metres at a normal pace, or climb 10-12 stairs without symptoms?
☐ Yes
☐ No

Date of Surgery/Procedure (DD/MM/YYYY): _ _/_ _/_ _ _ _

☐ **Cardiac Failure**

Date of last episode (DD/MM/YYYY): _ _/_ _/_ _ _ _

Is the patient's condition stable?
☐ Yes
☐ No

What is the patient's functional status? (Please select)
☐ No symptoms
☐ Shortness of breath with moderate exertion
☐ Shortness of breath with minimal exertion
☐ Shortness of breath at rest

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

	☐ **Syncope** Date of last episode (DD/MM/YYYY): _ _/_ _/_ _ _ _ Investigations? ☐ Yes ☐ No If yes, please describe results:
Respiratory Disorders ☐ Yes ☐ No	**If Yes, please fill out the appropriate section(s)**
	☐ **Chronic Pulmonary Condition** Recent Vital Signs: ☐ HR ☐ BR ☐ RR Date of Exam (DD/MM/YYYY): _ _/_ _/_ _ _ _ $Sp0_2$ ____% ☐ Room air ☐ Oxygen LPM ____ Date (DD/MM/YYYY): _ _/_ _/_ _ _ _ Has the patient deteriorated recently? ☐ Yes ☐ No Does the patient retain CO2? ☐ Yes ☐ No Has a Hypoxic Challenge Test been taken? ☐ Yes ☐ No Date of Test (DD/MM/YYYY): _ _/_ _/_ _ _ _ Results: Can the patient walk 50 metres at a normal pace or climb 10-12 stairs without symptoms? ☐ Yes ☐ No

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Does the patient have shortness of breath at rest?
☐ Yes
☐ No

Does the patient use supplemental oxygen on the ground?
☐ Yes
☐ No
If yes, please complete this section.

Oxygen Used at Rest:
Oxygen Tank Flow Rate: ____LPM
OR
POC Model Name: _____
Pulsed Flow Setting: _____
Continuous Flow Rate: ____LPM

Oxygen Used on Exertion:
Oxygen Tank Flow Rate: ____LPM
OR
POC Model Name: _____
Pulsed Flow Setting: _____
Continuous Flow Rate: ____LPM

Does the patient require a Personal Oxygen Concentrator (POC) in flight?*
☐ Yes
☐ No

Room Air $Sp0_2$____%
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _
Please be aware that oxygen requirements will be higher during the flight than on the ground.

Is the patient familiar with their Personal Oxygen Concentrator (P.O.C.) and capable of managing the device on their own, including responding to alerts and changing batteries?
☐ Yes
☐ No

Does the patient have enough batteries to last at least 1.5 times the duration of their flight? *Please note aircraft do not have electrical outlets able to supply power to a P.O.C.*
☐ Yes
☐ No

*If your patient requires oxygen services, they must contact the airline operating their flight for more information.

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Psychiatric Conditions (if relevant) ☐ Yes ☐ No	**If Yes** Diagnosis: Is there a possibility the patient will become agitated during the flight? ☐ Yes ☐ No Is the patient able to consent and to make self-care decisions? ☐ Yes ☐ No Does the patient present any cognitive issues? ☐ Yes ☐ No Is the patient oriented x3 (to person, place and time)? ☐ Yes ☐ No If no, please explain:
Seizures ☐ Yes ☐ No	**If Yes** Seizure type: Frequency: Date of last episode (DD/MM/YYYY): _ _/_ _/_ _ _ _ Are the patient's seizures controlled by medication? ☐ Yes ☐ No

Additional Seating Requirements
If your patient requires additional seating on their flight, please select from the following two reasons:

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

☐ **Additional Seating for Reasons of Disability**

In accordance with applicable regulations, the airline will provide an adjacent seat in certain situations. This includes seating for a support person assisting a passenger with a disability. Fares and/or related fees may apply, based on itinerary and local regulations.

Responsibilities of a Support Person

Flight attendants are not authorized to give special assistance (e.g. nursing care, lifting, feeding) to passengers with medical needs, as they are responsible for all passengers on board. Flight attendants are trained in first aid procedures only and are not permitted to administer any injection or give medication. Please ensure the passenger's support person can provide all necessary assistance.

Does your patient **require a support person to sit and remain upright** in a standard aircraft seat **when the seat is required to be in the upright position**, such as during takeoff and landing?	☐ Yes ☐ No
Does your patient require a support person to assist with their needs on board, such as **feeding, taking medication, or using the washroom**?	☐ Yes ☐ No
Does your patient require a support person to **transfer them to or from an aircraft seat during flight**?	☐ Yes ☐ No
Does your patient require a support person to **orient themselves or to communicate**?	☐ Yes ☐ No
Does your patient require a support person to **assist them in the event of an emergency**, such as during an aircraft evacuation or decompression?	☐ Yes ☐ No

If Yes to any of the above, who should attend to your patient?

☐ Physician
☐ Nurse/Paramedic
☐ Non-Medical Support Person

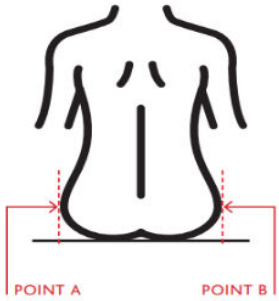
☐ **Additional Seating for Reasons of Obesity**

For itineraries wholly within Canada only

To determine the passenger's right to accommodation in the form of extra seating without charge, please provide the following measurements (metric):

Height: ____cm
Weight: ____kg
Body Mass Index: ____(kg/m2)
Surface Measurement* A to B: ____cm

**The Surface Measurement is the distance between the extreme widest projection points of the patient. To calculate, follow these instructions:*



1. Have your patient sit on a paper covered examination table.
2. Rest a ruler or straightedge on the left side of patient at the widest point (hip or waist) as shown in the diagram.
3. Mark the touch point between the ruler and the paper as Point A.
4. Rest a ruler or straightedge on the right side of patient at the widest point (hip or waist).
5. Mark the touch point between the ruler and the paper as Point B.
6. Measure the distance between Point A and Point B. This number is the "Surface Measurement."

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _

Additional Remarks and Signature	
Is there anything else not covered above that should be considered to determine your patient's fitness for air travel and their safety during their flight? If Yes, please specify:	☐ Yes ☐ No

Designated Healthcare Provider's Signature	First Name	**Date Signed** (DD/MM/YYYY)
x_____	Last Name	_ _/_ _/_ _ _ _

Healthcare provider initials: ____
Date (DD/MM/YYYY): _ _/_ _/_ _ _ _