(office logo)

office name

office address

office contact

Date……

MEDICAL CERTIFICATE FOR AIR TRAVEL

Name……Gender……..Age……year……..month……

Nationality……Passport Number/ID Number……

Airline……Flight no…… ☐ Depart ☐ Arrival ☐ Transit

Diagnosis……

……

Treatment……

……

……

……

Recommendation for air travel

☐ Fit for air travel

☐ Not fit for air travel

……

……

(office stamp)

Attending physician signature……(……) MD.

Medical License no……

Passenger signature……(……)

Note: With full knowledge that there may be known or unknown risk and complication of air travel, it is still my desire to refuse the recommended medical care. I accepted to travel on my own risk.

Passenger signature……Date and time……