FITNESS TO FLY CERTIFICATE

This is to certify that Mr. / Ms. ----------, aged -----, M/F, is diagnosed to have ---------- and is / was under my treatment.

The general condition and vitals of the patient are now stable.

The patient does not have any contagious / communicable disease.

He / She does / does not require Oxygen on board and is fit to travel by air by self / with attendant.

He / She will require / not require wheel chair assistance.

Doctor's Name:-

Qualification:-

Registration number:-

Contact Number:-

Rubber Stamp:-

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If Oxygen is required to fill the MEDIF form.