

Information Sheet for Passengers Requiring Special Assistance

Attachment A - to be completed by the passenger (handling advice for airlines staff)

IATA Resolution 700 Attachment A

1	Passenger's full name	Title	Age	Gender	
	Booking Number				
3	Flight No.	From	To	Date	Class
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4	Reason for assistance required (e.g.: woman over 32 week of pregnancy; infant up to 7 days of age; passenger requiring additional oxygen etc.)				
5	Do you require an assistance during the journey? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	A. If YES, specify the full name of the assisting person				
	B. Specify booking number (if different)				
6	C. Specify his/her medical qualifications (physician, nurse)?				
	Do you require a special assistance at the airport?				
	<input type="checkbox"/> WCHR – You are able to walk up/down stairs				
	<input type="checkbox"/> WCHS – You are unable to walk up/down stairs				
7	<input type="checkbox"/> WCHC – You are unable to walk				
	<input type="checkbox"/> I do not need				
	A. Do you need to transport a wheelchair? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	If YES, specify the type of wheelchair:				
	<input type="checkbox"/> manually powered wheelchair WCMP				
	<input type="checkbox"/> with non-spillable batteries WCBD				
	<input type="checkbox"/> with spillable cell batteries WCBW				
7	<input type="checkbox"/> with lithium-ion batteries WCLB				
	B. Is the wheelchair collapsible? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	Please provide the size of wheelchair (if possible, when folded):				
	Length (cm): _____ Width (cm): _____ Height (cm): _____ Weight (kg): _____				
	For battery powered wheelchair, please provide:				
8	Number of batteries: _____ Parameters of each battery in watt-hours (Wh): _____				
	In case of battery powered wheelchairs, electrical cabling must be protected and isolated by the owner against accidental short circuits.				
8	Do you need on-board wheelchair WCOB to assist with getting to/from the toilet? <input type="checkbox"/> YES <input type="checkbox"/> NO				
9	Do you need an ambulance? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	Provide contact details of the company providing the ambulance				
10	Ambulance arrangements must be made by the passenger, their insurance provider, or an assistance service.				
	A. Do you need additional oxygen during flight? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	If YES, remember that you must use your own portable oxygen concentrator (POC) during the flight.				
	Specify brand and model of POC: _____				
10	Length (cm): _____ Width (cm): _____ Height (cm): _____ Weight (kg): _____				
	Number of batteries: _____ Parameters of each battery watt-hours (Wh): _____ Type of batteries: _____				
	B. As the POC cannot be powered from the on-board socket, I confirm that I have extra batteries that will last 150% of the flight time. <input type="checkbox"/> YES <input type="checkbox"/> NO				
11	Example: If the flight is 8 hours long, you must bring enough battery power to last 12 hours of flying.				
	Please note that the service of carrying or providing an oxygen cylinder on board is not available.				
11	Other forms of assistance <input type="checkbox"/> YES <input type="checkbox"/> NO				
	If YES, specify:	Departure airport	Transit airport	Arrival airport	

Data Protection and Privacy Consent Declaration:

The personal and medical details you provide on this form, or attached to this form, will be used by Polskie Linie Lotnicze LOT S.A. to handle your request for medical clearance and to arrange the necessary assistance for your travel arrangements.

In order to assess and manage your request, and in order to arrange for the appropriate assistance, care and equipment, LOT Polish Airlines S.A. will be processing your personal details. It may also be necessary to disclose these details to other airlines in your itinerary and to third parties, such as medical professionals, airport and airline staff, government bodies and border control authorities. In cases where you also request mobility assistance we may need to provide your information to relevant service providers.

Detailed information can be found in the privacy policy of LOT Polish Airlines S.A.

I hereby consent to my personal and/or medical data being processed, used and/or disclosed for the purposes set out above.

Passenger's signature

Place and Date



Information Sheet for Passengers Requiring Medical Clearance

Attachment B Part One - to be completed by the attending physician

IATA Resolution 700 Attachment B

This form is intended to provide **confidential** information to assess the health of the passenger to travel as indicated. If the passenger is acceptable, this information will permit issuance of the necessary directives designed to provide for the passenger's need and comfort. The incapacitated passenger's attending physician is requested to answer all questions.

12	Passenger's full name	Age	Gender
13	Attending physician's full name	e-mail	
	Address	Telephone (+ country code)	
14	Diagnosis (dates of last treatment and onset of illness or information concerning pregnancy)		
	Nature and date of any recent and/or relevant surgery:		
15	Current symptoms and their severity. Is there an infectious disease present? If so, please provide details		
16	Will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition? (Cabin pressure to be the equivalent of a fast trip to a mountain elevation of 2400 meters/8000 feet above sea level) YES <input type="checkbox"/> NO <input type="checkbox"/> Not sure <input type="checkbox"/>		
17	Does the passenger have: A. Anemia YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please provide recent result in grams of hemoglobin <input type="text"/> B. Cardiovascular problems YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please complete points 22-24. C. Respiratory problems YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please complete point 25. D. Psychiatric disorder YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please complete point 26. E. Seizures YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please complete point 27. F. Does the passenger use oxygen at home? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please specify how much <input type="text"/> G. Controlled urination YES <input type="checkbox"/> NO <input type="checkbox"/> H. Controlled defecation YES <input type="checkbox"/> NO <input type="checkbox"/> If NO is indicated under G and/or H, the passenger must travel with an accompanying person.		
18	Is the passenger fit to travel unaccompanied? YES <input type="checkbox"/> NO <input type="checkbox"/> A. If NO, is the assistance provided by the airline sufficient? YES <input type="checkbox"/> NO <input type="checkbox"/> B. If NO, who should escort the passenger (medical qualifications: physician, nurse)? <input type="text"/> C. If the accompanying person is not medically qualified, is he or she fully capable of providing all necessary support? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19	Sitting position Is the passenger able to remain seated for the duration of the journey, if required? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20	Does the passenger need medication other than those taken independently? YES <input type="checkbox"/> NO <input type="checkbox"/> A. At the airport YES <input type="checkbox"/> NO <input type="checkbox"/> B. On board YES <input type="checkbox"/> NO <input type="checkbox"/> If YES is indicated under A and/or B, the passenger must travel with an accompanying person.		
21	Does the passenger need to use other medical equipment, eg. a ventilator? A. At the airport YES <input type="checkbox"/> NO <input type="checkbox"/> B. On board YES <input type="checkbox"/> NO <input type="checkbox"/> If YES is indicated under A and/or B, please provide: Type of device _____ Length (cm): _____ Width (cm): _____ Height (cm): _____ Weight (kg): _____ Number of batteries: _____ Parameters of each battery in watt-hours (Wh): _____ Type of batteries: _____ If a passenger needs to use a medical device during a flight, the device must be able to operate on battery power for at least 150% of the flight time, e.g. if the flight is 8 hours long, you must bring enough battery power to last 12 hours of flying.		
22	Cardiac condition A. Symptoms of angina? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, when was the last episode? <input type="text"/> Is the condition stable? YES <input type="checkbox"/> NO <input type="checkbox"/> B. Functional class of the passenger? <input type="checkbox"/> No symptoms <input type="checkbox"/> Angina with important efforts <input type="checkbox"/> Angina with light efforts <input type="checkbox"/> Angina at rest Can the passenger walk 100 meters at a normal pace or climb 10 - 12 stairs without symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/>		

Information Sheet for Passengers Requiring Medical Clearance

Attachment B Part Two - to be completed by the attending physician

IATA Resolution 700 Attachment B

23	Myocardial infraction	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date: _____
	A. Complications?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES, please provide details: _____
	B. Stress EKG done?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES, what was the result? _____ Metz
	C. If angioplasty (bypass):	Can the passenger walk 100 meters at normal place or climb 10 - 12 stairs without symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/>		
24	Cardiac failure?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	A. If YES, when was the last episode?	_____		
	B. Functional class of the passenger?	<input type="checkbox"/> No symptoms <input type="checkbox"/> Shortness of breath with important efforts <input type="checkbox"/> Shortness of breath with light efforts <input type="checkbox"/> Shortness of breath at rest		
Can the passenger walk 100 meters at normal place or climb 10 - 12 stairs without symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/>				
25	Chronic pulmonary condition	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	If YES, please complete the following sections:			
	A.	Has the passenger had recent arterial blood gases? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please provide date of test _____		
	B.	Blood gases results were taken on <input type="checkbox"/> room air <input type="checkbox"/> oxygen Liters per minute (LPM) _____		
		What were the results? Saturation _____ pCO ₂ _____ pO ₂ _____		
	C.	Does the passenger retain CO ₂ ? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	D.	Has the passenger condition deteriorated recently? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E.	Can the passenger walk 100 meters at a normal pace or climb 10 - 12 stairs without symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/>			
F.	Has the passenger ever taken a commercial aircraft in the same health conditions? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	If YES, when? _____			
	Did the passenger have any problems? _____			
26	Psychiatric Conditions			
	A.	Is there a possibility that the flight will adversely affect the passenger's psychiatric condition? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	B.	Is there a possibility that the passenger's psychiatric conditions during the flight will cause stress or discomfort to other passengers? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	C.	Has the passenger taken a commercial aircraft before? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	If YES, please provide date of travel: _____			
	Has the passenger travelled alone? YES <input type="checkbox"/> NO <input type="checkbox"/>			
27	Seizures?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	A.	What type of seizures? _____		
	B.	Frequency of the seizures? _____		
	C.	When was the last seizure? _____		
	D. Are the seizures controlled by medication? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28	Syncope?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	If YES, when was the last episode? _____			
29	What is the passenger's health condition before the journey?	GOOD <input type="checkbox"/>	POOR <input type="checkbox"/>	
30	To be completed only if the passenger is pregnant			
	Please specify:			
	A.	Single pregnancy <input type="checkbox"/> Multiple pregnancy <input type="checkbox"/>		
	Pregnancy week: _____			
	B. <input type="checkbox"/> I confirm that the passenger or child does not have any known complications contraindicating the flight.			
31	A. Passenger is fit to fly	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
	B. Date of completion	_____		
	Physician's signature and stamp	_____		

In a medical situation, cabin crew is trained solely to provide first aid. They are not authorized to administer injections, give medication, or lift or carry passengers.

PASSENGER'S DECLARATION:

I hereby authorize: _____
(name of nominated physician)

to provide the airlines with the information required by those airlines' medical departments for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith. I take note that, if accepted for carriage, my journey will be subject to the general conditions of carriage/tariffs of the carrier concerned and that the carrier does not assume any special liability exceeding those conditions/tariffs. I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.

Passenger's signature

Place and Date