

Medical Certificate to Fly

**Certificate No.:** [Unique Identifier]
**Date Issued:** [Date]
**Valid Until:** [Date]

**Physician Information:
Name:** Dr. [Physician's Full Name]
**License No.:** [Physician's Medical License Number]
**Contact Information:** [Physician's Contact Details]
**Address:** [Physician's Office Address]

**Patient Information:
Name:** [Patient's Full Name]
**Date of Birth:** [DOB]
**Address:** [Patient's Address]
**Contact Information:** [Patient's Contact Details]

**Medical Evaluation:**

* **Date of Examination:** [Date]
* **Summary of Medical Condition:** [Brief Description of the Medical Condition]
* **Relevant Medical History:** [Relevant Medical History that pertains to flying]
* **Medications Prescribed:** [List of Medications if applicable]

**Fitness to Fly Assessment:**Based on the medical examination conducted on [Date of Examination], I certify that:

* [Patient's Full Name] is medically fit to undertake air travel without posing a risk to themselves or others onboard.
* Necessary medical precautions and care required during the flight have been detailed to the patient and, if applicable, to the flight crew.
* The patient has been advised of the potential health risks associated with air travel given their current medical condition and has consented to undertake the journey.

**Special Accommodations Recommended:** [List any recommended accommodations, e.g., additional oxygen, wheelchair accessibility, etc., if applicable]

**Physician's Declaration:**I, Dr. [Physician's Name], hereby certify that the information provided herein is accurate and true based on my professional assessment of [Patient's Full Name]'s current medical condition.

**Signature:**[Physician's Signature]
**Date:** [Date of Signing]

**[Clinic/Hospital Seal, if applicable]**