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]