



South Willamette Valley Honor Flight

Medical Certificate of Fitness for Air Travel – Veteran

Mail Form to: South Willamette Valley Honor Flight, attn: Applications at PO Box 72150, Springfield, OR 97475
or scan and email to Applications@swvhonorflight.org

SOUTH WILLAMETTE VALLEY HONOR FLIGHT honors the United States Military Veteran for their service and sacrifice by escorting them to Washington DC to see their memorials and monuments at no cost to them.

A volunteer Guardian is assigned to each Veteran to escort and assist them throughout the duration of the trip. We use charter buses to transport once we arrive in DC. The flights there and back are approximately 6 hours with no stops. We walk about 6 miles over 3 days. We provide wheelchairs for Guardians to push Veterans in, whenever needed. Guardians room with their veteran; ADA accommodations can be requested in hotels.

This form is to be filled out by a Medical Practitioner, and is intended to provide confidential information about your patient to ensure we provide for their special needs. Thank you for helping us ensure a safe, memorable, and rewarding experience for this Veteran patient!

PATIENT INFORMATION			
NAME:	SEX: M / F	WEIGHT:	HEIGHT:
ADDRESS:			DATE OF BIRTH:
Please list medical conditions, physical disabilities, contagious/infectious or communicable disease, and/or restrictions that would limit the patient's overall success on their Honor Flight:			

Please check the following boxes as appropriate; if "Yes," please list details in the space provided above:

- Patient requires assistance to sit upright Yes No
- Patient requires in-flight assistance, including use of toilet facilities Yes No
- Patient requires medical oxygen / portable oxygen concentrators for flight Yes No
- Patient requires use of wheelchair Yes No
- Patient requires assistance getting in/out of bed, on/off toilet, in/out of wheelchair Yes No
- Patient requires assistance remembering to take prescription medication(s) Yes No
- Patient uses a colostomy or urostomy bag Yes No

If "Yes", does patient require assistance regarding this Yes No

Based on the above, I hereby declare that the patient **IS** fit to travel
 NOT fit to travel

Medical Practitioner Name: _____

License No: _____

Medical Practitioner Signature: _____

Date: _____