Solomon Airlines Medical Travel Clearance Form - Part A

Prior to travel
1. This form is to be used by passengers whom have a medical condition and intend to travel on a flight operated by Solomon Airlines including its subsidiaries.
2. This form is to be completed by the treating medical practitioner ensuring the Travel Clearance Guidelines are referred to assist in making a determination if a passenger is fit to travel by air.
3. If the Travel Clearance Guidelines indicate further information is required, a corresponding Part B form must also be completed by the treating medical practitioner.
4. A copy of the Travel Clearance form must be returned to Solomon Airlines at your earliest convenience prior to the proposed date of travel. All sections must be completed.
5. Please return both Part A and Part B (where required) to: E: reservations@flysolomons.com
6. If you as the medical practitioner believe that special consideration should apply to an individual patient, please contact our reservations team and they will provide the details for our medical team.

1. PASSENGER DETAILS (to completed by the passenger)

<table>
<thead>
<tr>
<th>NAME:</th>
<th>AGE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE NUMBER:</td>
<td></td>
</tr>
</tbody>
</table>

2. TRAVEL INFORMATION (to be completed by the passenger)

| Booking ref #: |

<table>
<thead>
<tr>
<th>Flight Sector</th>
<th>Date of flight</th>
<th>Flight Number</th>
<th>Travelling from</th>
<th>Travelling to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. MEDICAL INFORMATION (to be completed by the treating Doctor)

* Non completion of this section will result in this form being returned, which may cause a delay in travel

Medical Condition:

Date of Diagnosis:

**(including onset of current illness, episode, accident and treatment)**

Date of Surgery:

4. OXYGEN REQUIREMENTS (to be completed by the treating Doctor)

(a) Is supplemental oxygen required in flight? □ NO □ YES

(b) If YES Flow rate 2L/ min Intermittent / Continuous

4L/min Intermittent / Continuous

Passenger to provide their own oxygen with the tank not exceeding 5kg in weight.
5. ASSISTANCE REQUIREMENTS (to be completed by the treating Doctor)

(a) Is a wheelchair required to the aircraft door/seat  □ NO □ YES □ DOOR □ SEAT
(b) Can the passengers walk up and down stairs □ NO □ YES
(c) Is an escort required inflight to assist with eating, medications and toileting? □ NO □ YES
(d) Is a medically trained escort necessary? □ NO □ YES

If YES, name and medical qualifications must be completed:

Name of Escort ____________________________________________
Qualifications of Escort _____________________________________
Booking Reference _________________________________________

(e) Is any of the following equipment required? □ NO □ YES

YES If YES please specify:  □ Stretcher*
□ Humidicrib *
□ Other medical equipment**

(*An ambulance is required for all stretcher and Humidicrib cases, clearance cannot be provided until ambulance bookings are confirmed) (** All electrical medical equipment must be approved)

Additional clinical information may be required: (please indicate if YES and complete Part B)

1. Cardiopulmonary □ NO □ YES (if YES complete PART B)
2. Cancers □ NO □ YES (if YES complete PART B)
3. Neurological □ NO □ YES (if YES complete PART B)
4. Psychiatric □ NO □ YES (if YES complete PART B)

6. DOCTORS DECLARATION (to be completed by the treating Doctor)

I have read and understood the Solomon Airlines travel Clearance Guidelines and I certify that the above-named passenger has been assessed by me as fit to travel on the nominated flights. I further certify that this person does not have any contagious disease that could directly place another passenger or the crew at risk, or that would contravene relevant Quarantine or Public Health Departments regulations.

I, (name of doctor) ___________________________________________ hereby declare that to the best of my knowledge, (name of passenger) ________________________ is fit to travel.

(As a courtesy, Solomon Airlines may notify any doctor who clears a passenger for travel if the condition of the passenger deteriorates inflight, or if the level of care required for that passenger results in an interruption to normal operations.)

Doctor’s signature and qualifications ___________________________ Date ___________________________

Practice contact number (business hrs) ___________________________ After hours contact number ___________________________

7. PASSENGERS DECLARATION (to be completed by the passenger)
Travel Clearance Guidelines

I declare that the information contained on this Part A and Part B (where applicable) is complete and accurate. I authorize Solomon Airlines to use and release this information as required in the event of an emergency. I acknowledge that airline staff are not medically trained and that the airline cannot guarantee that I will receive appropriate medical attention in any situation. I acknowledge that Solomon Airlines reserves the right to refuse travel, notwithstanding completion of this form, if the airline considers that it is not in my best interest to fly.

<table>
<thead>
<tr>
<th>Passenger signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Solomon Airlines Privacy Collection Notice

Solomon Airlines collects information about you (including health information where necessary) to provide products and services to you, facilitate your participation in our and other organisations’ loyalty programs, ensure the safety and security of all passengers when travelling with us, conduct marketing activities for our and third parties’ products and services and conduct market research.

We may collect your personal information from people who make or update your travel booking or otherwise interact with us on your behalf, from our related bodies corporate entities, from our service providers and from immigration, customs, border security and other regulatory authorities.

For the reasons described above, we may disclose your personal information to:

- our related companies, other carriers and organisations which provide services to us (such as ground handling and other travel related services, call centre operation, market research and marketing services, and services associated with complaints or security incident investigation);
- your employer if you are travelling for work purposes on a ticket purchased by your employer*; and
- others to comply with our legal obligations, including to various law enforcement agencies, regulatory authorities and governments for security, customs and immigration purposes.

These parties may be located overseas including in the United Kingdom, the United States, Germany and any country which you travel to or through with us or our partner airlines.

*The information disclosed to your employer may include your travel details and any information associated with your travel (such as incident reports).
Solomon Airlines Group Medical Travel Clearance Form - Part B

### 1. CARDIOPULMONARY

- **Is the condition stable?**
  - [ ] YES  [ ] NO  
- **When was the last episode or event?**
  - Date:
- **Exercise tolerance (can the patient walk at a moderate pace 50m or climb 10-12 stairs without symptoms?)**
  - [ ] YES  [ ] NO
- **Stress ECG undertaken?**
  - [ ] YES  [ ] Results:
  - [ ] NO
- **Is the patient controlled with medication?**
  - [ ] YES  [ ] NO
- **Recent arterial gases?**
  - [ ] YES  [ ] NO
- **Does the patient retain CO2?**
  - [ ] YES  [ ] NO
- **Have they required ventilatory support within last 14 days?**
  - [ ] YES  [ ] NO

### 2. CANCERS

- **Stage classification:**
  - [ ] Stage I  [ ] Stage II  [ ] Stage III  [ ] Stage IV
- **Evidence of metastatic disease in brain, or lungs?**
  - [ ] YES  [ ] NO
- **Any evidence of seizures?**
  - [ ] YES  [ ] NO
- **Is respiratory disease or symptoms?**
  - [ ] YES  [ ] NO
- **Has there been a recent/ significant deterioration?**
  - [ ] YES  [ ] NO
- **Is the patient currently receiving chemotherapy?**
  - [ ] YES  [ ] NO
- **Patients short-term prognosis:**
- **Are there any compassionate reasons for travel?**
  - [ ] YES  [ ] NO

### 3. NEUROLOGICAL

- **Does this patient have seizures?**
  - [ ] YES  [ ] NO
- **When was the last seizure?**
- **Frequency of seizures:**
  - Daily  Weekly  More than 1 a month
- **Are the seizures controlled by medication?**
  - [ ] YES  [ ] NO
- **Date of head injury:**
- **Loss of consciousness?**
  - [ ] YES  [ ] NO
- **Base of skull fracture:**
  - Subdural haematoma
  - Subarachnoid haemorrhage
- **Evidence of pneumocranium?**
  - [ ] YES  [ ] NO
- **Evidence of CT scan cranium free of air?**
  - [ ] YES  [ ] NO

### 4. PSYCHIATRIC (including drug and alcohol issues)

- **Does the patient a history of psychosis?**
  - [ ] YES  [ ] NO
- **Is the patient a risk to themselves or others?**
  - [ ] YES  [ ] NO
- **Does this patient have a history of violence?**
  - [ ] YES  [ ] NO
- **Is the patient currently stable on medication?**
  - [ ] YES  [ ] NO
- **Is the patient compliant to all reasonable instructions?**
  - [ ] YES  [ ] NO
- **Is the passenger withdrawing from alcohol or other drugs?**
  - [ ] YES  [ ] NO
Dear Doctor,

In order to completely assess your patient’s fitness to fly, we appreciate you providing as much medical information as is possible, this allows our Medical Department to review and appropriately risk assess travel to ensure your patient reaches their destination safely and well.

For complicated medical cases, the Solomon Airlines medical team is available to discuss your patient’s case, please request to be connected through our reservations team reservations@flysolomons.com.

Please provide by free text any further relevant medical information as below:

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Doctors signature                      Date