

**MEDICAL REPORT**

**Part 1: To be completed by travel agent or passenger** تملأ بمعرفة الراكب أو الوكيل السياحي

**It must be signed and dated. PLEASE USE ONLY BLOCK "CAPITAL" LETTERS**

**1- Passenger Details** بيانات الراكب:

Name (as per PNR) الأسم	
Telephone number رقم الهاتف	
Passenger's Doctor Number اسم و رقم هاتف الطبيب	

**2- FLIGHT DETAILS:** بيانات الرحلة:

\*NOT ALLOWED TO ADD TO FLIGHTS, EACH FLIGHT TO HAVE A SEPARATE FORM تملأ استمارة منفردة لكل رحلة

PNR	Flight No.	Date	From	To	Class	Status

**3- NATURE OF INCAPACITATION** المسمى الطبي للحالة المرضية :

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**4- ASSISTANCE REQUIRED (Tick  against the relevant):** الخدمات الطبية لمطلوبه من قبل النيل للطيران خلال الرحلة

STRETCHER	
OXYGEN	
WHEELCHAIR (Specify WCHR,WCHS or WCHC)	
SPECIAL MEAL (Has to be advised 72 hours and subject to refuse or acceptance)	
APPROVAL FOR CARRIAGE OF MEDICAL EQUIPMENT. Required advanced approval for equipment	
Assistance "Blind / Hearing" Dog	
NO ASSISTANCE REQUIRED	

**5- ESCORT DETAILS (Tick  against relevant)** بيانات الراكب المرافق للمريض :

NOT REQUIRED  PERSONAL (NON-MEDICAL) ESCORT  NURSE  DOCTOR

Name of the Escort		PNR	
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## MEDICAL REPORT



### Part 2: To be completed by the treating or attending doctor and Passenger

يملأ و يوقع و يختم بواسطة الطبيب المعالج او المستشفى المعالج . ثم يوقع بواسطة الراكب بعد اسفاء كل البيانات الطبيه المطلوبة

### **PASSENGER'S DECLARATION & PASSENGER'S DOCTOR DECLARATION:**

I hereby authorize ..... (Name of nominated physician ) to complete **this form** for the purpose as indicated overleaf 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(s) concerned and that the carrier(s) do not assume any special liability exceeding those Conditions/tariffs. I am prepared at my own risk to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from liability for such consequences. I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.

I have read and understood all form conditions

Full details for Passengers' case: Please provide full medical explanation in clear stating,  
Fill in or attach a doctor report

**Doctor Name & specialization:**

**Date**

**Doctor stamp**

<b>Passenger Signature</b>	
<b>Or passenger relative signature</b>	
<b>Passenger's Doctor Signature</b>	
<b>Date</b>	