# REQUEST FOR ONE PERSON ONE FARE

**PASSENGER INFORMATION**

| | | | |
|---|---|---|---|
| Passenger Last Name | | Departure Date | |
| First Name | | Return Flight Date | |
| Departure Airport | | Booking number | |
| Arrival Airport | | Phone (+ area code) | |
| Email | | | |

I authorize Air Transat to retain this information for 3 years electronically YES NO

Passenger signature

Date

**The following passengers are pre-approved for the ONE PERSON ONE FARE program:**

1. A person with a disability who had been approved by Air Transat's SUPPORT PERSON program
2. A person with a visual impairement who holds a valid CNIB card

Any other passenger must have page 2 of this form submitted for approval.

**Thank you for returning this form at time of booking to: request@airtransat.com**
**Please present a printed copy of this form at each departure airport**

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***MEDICAL / MENTAL HEALTH PROFESSIONAL INFORMATION***

***This form must be completed by the passenger's Physician and submitted at the time of booking but no later than 48 hours prior to departure. You may submit a separate letter only if it includes all of the information below, is on letter head, and includes the signature of the Doctor. If the passenger has been approved for a SUPPORT PERSON, then they are automatically approved for OPOF on its applicable routes.***

**To be completed by the Physician**

Passenger Last Name ____________ First Name ____________

**Check all that are applicable:** **Check**

I am a licensed Physician who is currently treating the passenger listed above. ☐

I confirm that the passenger, because of a disability, requires a personal care attendant in order to provide assistance during a flight. Describe assistance required: ____________ ☐

I confirm that the passenger is hearing impaired and requires an interpreter during flight. ☐

I confirm that the passenger, because of a disability, requires additional space due to: ☐

I confirm that the passenger, because of obesity, is disabled and requires an additional seat due to size. ☐

_______ Weight in KG Height in CM ________

_______ Weight in LB Height in FT ________

Seated surface measurement from the widest point _____ /CM or _____ / IN

As this is a static condition, I authorize Air Transat to consider this approval for a period of up to 3 years from this date. ☐

Name of practice ____________

Signature ____________

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