REQUEST FOR SUPPORT PERSON

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

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

REQUEST FOR SUPPORT PERSON

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. Air Transat's approval or requirement to travel with a SUPPORT PERSON qualifies as eligibility for the Air Transat ONE PERSON ONE FARE Program.

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 requires assistance when flying with eating meals, taking medication, or using the washroom.	☐
I confirm that the passenger requires assistance with transferring to and from a passenger seat.	☐
I confirm that the passenger requires physical assistance to put on a seat belt, or in the case of an emergency, an oxygen mask, or assistance to evacuation the aircraft if required.	☐
I confirm that the passenger requires assistance with orientation or communication.	☐
I confirm that the passenger is unable to understand or respond to safety directions from the crew because of a mental or cognitive disability.	☐
I confirm that the passenger is unable to receive safety information, intructions or evacuation information directives because of both hearing and vision impairments.	☐
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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