



Pilots for Christ

PO Box 707, Monroeville, Alabama 36461 Phone: 251.575.9425 (no fax capability) info@pilotsforchrist.com

PHYSICIAN EVALUATION OF ELIGIBILITY

Patient Name: _____ Age: _____ Sex: _____ Weight: _____

Address: _____ City, State, Zip Code: _____

Patient's Medical Diagnosis and Reason for Travel: _____

Physician's Name: _____ Email _____

Address: _____ City, State, Zip Code: _____

Telephone: _____ EXT: _____

Medical reason for requested travel:

Please check the box(es) that apply.

_____ Compassion (physically unable to travel by any other means): Explain: _____

_____ Low Immunity System

_____ Other, please explain: _____

PLEASE NOTE: Pilots for Christ, Inc. is not an air ambulance service and will not provide any medical attention before, during, or after the flight. We cannot accept an application if the person requires any life support equipment, incubator, etc. although a wheelchair may be accepted.

Please list any special equipment needed by this patient during flight (if any): _____

Does the patient's condition require this form to be updated? Yes _____ No _____ If so, how often _____

To the best of my knowledge, this patient/family is eligible for charitable transportation. I am sufficiently familiar with aviation physiology to be of the opinion that this patient can travel in small aircraft at ambient pressure altitudes up to 11,000 feet above sea level, and that said patient has no need of medical assistance before, during, or after the flight.

Signed: _____ M.D./D.O. Date: _____

Print Name: _____ Form Expiration Date: _____

Electronic signatures are acceptable. **NOTE THIS FORM MUST BE COMPLETED AND SUBMITTED VIA EMAIL TO PFC DIRECTLY FROM THE PHYSICIAN'S OFFICE AS SOON AS POSSIBLE. Email: info@pilotsforchrist.net**