LUFTHANSA GROUP
Medizinischer Dienst

Dear Customer,

Thank you for choosing Lufthansa City for your journey. We kindly ask you to complete the following form with your treating physician, preferably electronically or in block letters. **Please note the attached data protection declaration and your mandatory consent, so that we can process your request.** The necessary documentation can be sent by fax (+49 69 696 83677) or email (medicaloperation@dlh.de).

The personal and medical data provided on the following forms will be treated strictly confidential. However, the information is necessary for medical clearance and to cater to your specific medical needs during your journey.

Please note that our cabin crew is not authorized to give special assistance (e.g. nursing care, lifting, feeding, etc.) to passengers with medical needs, due to their responsibility for all passengers on board. Our crew is trained only in first aid and is not authorized to administer medication. If you are travelling with an electric wheelchair, please make sure to have information on battery capacity, battery removal and on how to turn off the wheelchair completely available.

Fees, if any, relevant to the provision of the above information and for carrier-provided special equipment (e.g. oxygen on-demand system, Wenoll-System) are to be paid by the passenger. Please note that family members are not allowed as medical escorts on our flights.

The conditions of transport, in particular the rules of liability, in the terms and conditions of Lufthansa City Airlines GmbH, apply.

We wish you a pleasant journey!

Kind regards,

Your

Medical Operation Center

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Information Sheet for Passengers Requiring Special Assistance

In accordance with the IATA Medical Manual, 11. Edition, Appendix „E“, Version June 2018

1.	**Name, first name:**			Title	Age	Gender
	Telephone:			Height	Weight	
	E-mail:					
2.	**Booking reference (PNR):**					
3.	**Routing from**	**To**	**Flight number**	**Class**		**Date**
4.	**Type of disability or required assistance:**					
5.	**Is the patient able to sit in a normal aircraft seat with seatback placed in the upright position?**			☐ yes		☐ no
6.	**Stretcher transport required?**			☐ yes		☐ no
	☐ Stretcher	Must travel on a stretcher. This requires medical assistance, either nurse/paramedic or a physician.				
	Please provide contact data of designated ambulance service for stretcher (see item 9)!					
7.	**Is the patient fit to travel unaccompanied and can he/she take care of all their needs onboard?**			☐ yes		☐ no
	Is an escort necessary for this journey?			☐ yes		☐ no
	Escort (name):			PNR		
	Medical qualification		☐ Physician	☐ Nurse/paramedic		☐ none
8.	**Wheelchair or assistance for boarding required?**			☐ yes		☐ no
	☐ WCHR	Ambulant but handicapped in walking: Needs assistance in terminal to/from gate, needs wheelchair or similar when passengers are boarding/disembarking by walking over ramp. Does not need assistance in a ramp bus, on passenger steps and in the aircraft cabin to/from seat, toilets and with meals.				
	☐ WCHS	Ambulant but more severely handicapped in walking: Cannot use a ramp bus and needs assistance in boarding/disembarking (e.g. on passenger steps). Does not need assistance in the aircraft cabin to/from seat, toilets and with meals.				
	☐ WCHC	Non-ambulant: Needs assistance in the aircraft to/from seat, toilets and possibly with meals.				
	☐ WCH OWN (own wheelchair)	☐ WCH BW (wet cell battery)	☐ WCH BD (dry cell battery)	☐ WCH LB (Li-battery)		☐ WCMP (manual)
	Battery capacity (Wh):		Weight:			☐ collapsible
	Dimensions/size (cm):					
9.	**Transport from/to airport by ambulance required?** (to be arranged by passenger/assistance/insurance)			☐ yes		☐ no
	Departure	Company:				
		Contact (telephone/e-mail):				
	Arrival	Company:				
		Contact (telephone/e-mail):				
10.	**Assistance at the airport required?**			☐ yes		☐ no
	Please specify:					
11.	**Other ground arrangements needed?**			☐ yes		☐ no
	Please specify:					
12.	**Special in-flight arrangements needed?**			☐ yes		☐ no
	Please specify (e.g. extra seat, medical equipment, etc.):					
	Technical clearance by airline granted?			☐ yes		☐ no
13.	**Frequent Medical Traveller Card (FREMEC) available?**			☐ yes		☐ no
	Valid until:		Issued by:			
	FREMEC issuance requested?			☐ yes		☐ no

Medical Operation Center
FRA PM/C

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Fax:+49 69 696 83677

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Information sheet for passengers requiring medical clearance (to be completed by the attending physician) – MEDIF, Part 1

In accordance with the IATA Medical Manual, 11. Edition, Appendix „E“, Version June 2018

1.	**Name, first name:**			
	Date of birth:	Gender:	Height:	Weight:
2.	**Attending physician (name):** Telephone: E-mail:			
3.	**Diagnosis:**		Date:	
4.	**Short history, onset of current illness, symptoms, treatment, etc.:**			
5.	**Medication list:**			
6.	**Will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition?** Cabin pressure to be the equivalent of a fast trip to a mountain elevation of 2.400 meters (8.000 feet) above sea level.			
	☐ yes	☐ no		☐ not sure
7.	**Has the patient ever taken a commercial aircraft in his/her current status?** If yes, date:		☐ yes	☐ no
	Did the patient have any problems? If yes, please specify:		☐ yes	☐ no
	Did the patient travel		☐ alone	☐ escorted
8.	**Has his/her condition deteriorated recently?**		☐ yes	☐ no
9.	**Can the patient walk without assistance?**		☐ yes	☐ no
10.	**Can the patient walk 50m or climb 10-12 stairs without symptoms?**		☐ yes	☐ no
11.	**Infection status / infectious disease**			
	a. Is it necessary to isolate the patient in medical facilities?		☐ yes	☐ no
	b. Is the accompanying medical personnel required to wear personal protective equipment (gloves, gown, mask, etc.)?		☐ yes	☐ no
	c. Is a colonization with multi-resistant germs or an acute contagious disease known? If yes, germ:		☐ yes	☐ no
12.	**Is a current blood gas analysis available? Saturation known?** If yes, date:		☐ yes	☐ no
	Room air	Saturation: %	pO2: (mmHg/kPa)	pCO2: (mmHg/kPa)
	O2 l/min	Saturation: %	pO2: (mmHg/kPa)	pCO2: (mmHg/kPa)
13.	**Additional medical information:**			
	a. Anemia If yes, Hb: g/dl, date:		☐ yes	☐ no
	b. Psychiatric disorder		☐ yes (see part 2)	☐ no
	c. Cardiac disorder		☐ yes (see part 2)	☐ no
	d. Pulmonary disorder		☐ yes (see part 2)	☐ no
	e. Does the patient use oxygen at home? If yes, l/min		☐ yes	☐ no
	f. Oxygen needed in flight? If yes, l/min		☐ yes	☐ no
	☐ O2 on-demand system (Wenoll-System) requested	☐ POC available/own POC Model:		
	☐ O2-bottle available (max. 5kg, 200bar, not allowed on flights to/from USA, Canada and Mexico) Volume/pressure:			
	g. Seizure disorder		☐ yes (see part 2)	☐ no
	h. Bladder control abnormal? If yes, mode of control:		☐ yes	☐ no
	i. Bowel control abnormal? If yes, mode of control:		☐ yes	☐ no

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In accordance with the IATA Medical Manual, 11. Edition, Appendix „E“, Version June 2018

14.	**Cardiac disorder**	☐ yes	☐ no
	Exercise ECG available? If yes, Watt/MET: , date:	☐ yes	☐ no
	Echocardiography available? If yes, EF: %, date:	☐ yes	☐ no
	Functional class/symptoms (angina, dyspnea)?	☐ yes	☐ no (NYHA 1)
	☐ with strenuous efforts (NYHA 2)	☐ with light efforts (NYHA 3)	☐ at rest (NYHA 4)
	a. Angina If yes, date:	☐ yes	☐ no
	Is the condition stable?	☐ yes	☐ no
	b. Myocardial infarction If yes, date:	☐ yes	☐ no
	Complications? If yes, please specify:	☐ yes	☐ no
	PTCA/PCI or CABG performed? If yes, date:	☐ yes	☐ no
	c. Cardiac failure If yes, date of last episode:	☐ yes	☐ no
	Is the patient controlled with medication?	☐ yes	☐ no
	d. Syncope If yes, date:	☐ yes	☐ no
	Complete work up performed?	☐ yes	☐ no
15.	**Pulmonary disorder**	☐ yes	☐ no
	a. Dyspnea	☐ yes	☐ no
	☐ with strenuous efforts	☐ with light efforts	☐ at rest
	b. Does the patient retain CO2?	☐ yes	☐ no
16.	**Psychiatric disorder**	☐ yes	☐ no
	a. Is there a possibility that the patient will become agitated during flight?	☐ yes	☐ no
17.	**Seizure disorder**	☐ yes	☐ no
	a. Type of seizures		
	b. Frequency of seizures		
	c. Date of last seizure		
	d. Are the seizures controlled by medication? If yes, medication:	☐ yes	☐ no
18.	**Any other relevant comment:**		
19.	**Prognosis for the trip:**	☐ good	☐ poor
20.	**Attending physician´s signature and seal:**	Date:	

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Data Protection and Privacy Consent Declaration

The personal and medical details you provide on this form (or have attached to this form) will be used by Lufthansa City to handle your request for medical clearance and to arrange the necessary assistance for your travel arrangements. In order to assess and manage your request, and in order to arrange for the appropriate assistance, care and equipment, a consent is required by article 9 paragraph 2 lit. a DSGVO. It may be necessary for Lufthansa City to process and/or disclose your personal and/or medical information to other airlines in your itinerary and to third parties, such as medical professionals, airport and airline staff, government bodies and border control authorities. In cases where you also request mobility assistance, we may need to provide your information to relevant service providers. Please note that without the following consent declaration we are unable to process your request further.
Please note that your medical data will be stored for 10 years. Further information on data protection can also be found on our website:
www.lufthansa.com/de/en/information-on-data-protection

Data protection officer:	Corporate data protection officer Deutsche Lufthansa AG E-Mail: datenschutz@dlh.de

I hereby consent to my personal and/or medical data being processed, used and/or disclosed for the purposes set out above.

I can withdraw my consent anytime. In case of my revocation, the Medical Operation Center will not process my personal data any further. The revocation can be send by mail, fax or e-mail to the Medical Operation Center (e-mail: medicaloperation@dlh.de).

Articles 15 – 21 DSGVO grant me the following rights:

- Right of access, art. 15 DSGVO
- Right to rectification, art. 16 DSGVO
- Right to erasure, art. 17 DSGVO
- Right to restriction of processing, art. 18 DSGVO
- Right to data portability, art. 20 DSGVO

Furthermore, I can lodge a complaint with the corresponding authorities (*) regarding the handling of my personal data.

(*) Regulartory Authority: Hessische Beauftrage für Datenschutz und Informationsfreiheit, Gustav-Stresemann-Ring1, 65189 Wiesbaden – Email: poststelle@datenschutz.hessen.de

☐ I agree to the above mentioned data processing.