



UNHAS
Humanitarian
Air Service

Medical Evacuation Request/Authorization

DATE:	
REQUESTING ORGANIZATION:	
REQUESTOR NAME AND TITLE:	
NAME OF LOCATION TO BE EVACUATED FROM:	
NUMBER OF STAFF TO BE EVACUATED:	

**NAMES AND DETAILS OF EVACUEES AS PER ATTACHED BOOKING FORM (LIST).
I DO CONFIRM THAT INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

Signature: _____

Stamp: _____

UN Doctor or recognized Medical Doctor/Hospital FIT TO FLY statement

NAME OF PATIENT:	YES	NO
THE PATIENT IS FIT TO FLY:		
THE PATIENT SUFFERS FROM A CONTAGIOUS DISEASE:		
THE PATIENT NEEDS TO FLY WITH A STRETCHER:		
THE PATIENT HAS TO BE ACCOMPANIED BY MEDICAL STAFF:		

DOCTOR REPORT, CERTIFICATION/STATEMENT OR OTHER COMMENTS:

Doctor's name
and signature: _____

Doctor's or
Clinic Stamp: _____

Clinic name and location: _____

AFTER MISSION REPORT

Pilot in command: _____

IMPORTANT REMARKS :