

درخواست برائے حصول سٹریچر

بنیادی معلومات

مریض کا نام: _____ اقامہ نمبر: _____
مریض کا پاسپورٹ نمبر: _____ درخواست دہندہ کا مریض سے رشتہ: _____
مریض کا پاکستان میں پتہ: _____ ضلع: _____
حادثے کی تفصیل: _____
مریض کی صورتحال: _____

ہسپتال اور ڈاکٹر کی معلومات

مریض گھر میں ہے یا ہسپتال میں: _____ ہسپتال کا نام: _____
معالج ڈاکٹر کا نام: _____ معالج ڈاکٹر کا رابطہ نمبر: _____
اگر مریض گھر میں ہے تو ہسپتال سے ڈسچارج ہونے کی تاریخ لکھیں: _____ / _____ / ۲۰۱۷

کفیل کی معلومات:

کفیل کا نام: _____ کمپنی کا نام: _____
کفیل کا پتہ: _____ رابطہ نمبر: _____
مریض کفیل کے ساتھ کام کرتا تھا یا آزاد کام کر رہا تھا: _____ مریض کی انشورنس کارآمد ہے یا نہیں: _____

میں حلفیہ بیان کرتا ہوں کہ مندرجہ بالا معلومات درست ہیں اور یہ کہ مریض کی حالت کی وجہ سے اس کا علاج سعودی عرب میں ممکن نہیں ہے۔ درخواست گزار یا مریض کے رشتہ دار پاکستان بھجوانے کے اخراجات برداشت کرنے کے قابل نہیں ہیں، اس لئے سفارتخانہ پاکستان ریاض سے استدعا ہے کہ مریض کی حالت زار کو مد نظر رکھتے ہوئے اس کو سٹریچر کی سہولت فراہم کی جائے۔

نام درخواست گزار: _____ رابطہ نمبر: _____
اقامہ نمبر: _____ پاسپورٹ نمبر: _____ دستخط: _____

- (مطلوبہ کاغذات): (۱) میڈیکل رپورٹ (۲) ائر لائن کا پرفارما (۳) مریض کے اقامہ کی کاپی
(۴) مریض کے پاسپورٹ کی کاپی (۵) مریض کے شناختی کارڈ کی کاپی (۶) مریض کی دو عدد تازہ تصویریں
(۷) درخواست گزار کے اقامہ کی کاپی ۔

نوٹ: اسٹریچر کی درخواست قطعاً سٹریچر کی منظوری نہیں ہے۔

PART 1

MEDIF

STANDARD MEDICAL INFORMATION FORM FOR AIR TRAVEL

To be completed

Answer ALL questions - Put a cross (x) in the "YES" or "NO" boxes

by
SALES OFFICE / AGENT

Use BLOCK LETTERS or TYPEWRITE when completing this form

NAME / INITIALS / TITLE

PROPOSED ITINERARY -
(Airline(s), flight number(s),
class(es), date(s), segment(s),
reservation status)

Transfer from one flight to another often
requires
LONGER connecting time.

NATURE OF INCAPACITATION

MEDICAL CLEARANCE REQUIRED? Yes No

IS STRETCHER NEEDED ON BOARD?
(All stretcher cases must be escorted)

Yes No

Request rate if unknown

INTENDED ESCORT (Name, sex, age,
professional qualification, segments if
different from passenger) If untrained,
state "TRAVEL COMPANION".

For the Blind and / or Deaf,
state if escorted
by a trained dog.

WHEELCHAIR NEEDED? No

Yes

Categories are:
WCHR WCHS WCHC

Wheelchair Category:

Own
Wheelchair? No

Yes

Collapsible? No

Yes

Power
Driven? No

Yes

Battery Type
(spillable)? No

Yes

Wheelchairs with spillable batteries are
"dangerous goods" and are permitted on
passenger aircraft only under certain
conditions, which can be obtained from
the airline(s). In addition, certain
countries may impose specific
restrictions.

AMBULANCE NEEDED? No

Yes

To be arranged by AIRLINE

No specify Ambul. Company contact

Yes specify destination address

OTHER GROUND
ARRANGEMENTS NEEDED? No

Yes

If Yes, SPECIFY below and indicate for each item (a) the ARRANGING airline or other
organisation, (b) whose EXPENSE, and (c) CONTACT addresses / phones where
appropriate or whenever specific persons are designated to meet / assist the passenger.

1 Arrangements for delivery at
airport of DEPARTURE. No Yes Specify:

2 Arrangements for assistance
at CONNECTING POINTS. No Yes Specify:

3 Arrangements for meeting at
airport of ARRIVAL. No Yes Specify:

4 Other requirements or
relevant informations. No Yes Specify:

SPECIAL IN-FLIGHT
ARRANGEMENTS NEEDED such as
special meals, special seating, leg-rest,
extra eat(s), special equipment, etc.

No Yes

If Yes, DESCRIBE and indicate for each item; (a) SEGMENT(S) on which required, (b)
airline ARRANGED or arranging third party, and (c) at whose expense. Provision of
SPECIAL EQUIPMENT such as oxygen etc., always requires completion of Part 2 overleaf.

See Note * at the end of PART 2
overleaf

DOES PASSENGER HOLD A "FREQUENT
PASSENGER'S MEDICAL CARD" VALID FOR
THIS TRIP? (FREMEC) No Yes

If Yes, add below FREMEC data to your reservation request. If No, (or if additional data
needed by carrying airline(s), have physician in attendance complete PART 2 hereof..

FREMEC

(FREMEC Number)

(Issued by)

(Valid until)

(Sex)

(Age)

(Incapacitation)

(Incapacit. cost.)

(Limitations)

PASSENGER'S DECLARATION:

I hereby authorize: _____ (Name of nominated Physician)
to provide the airline's with the information required by those airline's medical departments for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve
that physician of his / her professional duty of confidentiality in respect of such information, and agree to meet such fees in connection herewith.

I take note that, if accepted for carriage, my journey will be subject to the general conditions of carriage / tariffs of the carrier(s) concerned and that the carrier(s) do not assume any special liability
exceeding those conditions / tariffs.

I am prepared, at my own risk, to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from any liability for such
consequences.

I agree to reimburse the carrier(s) upon demand for any special expenditures or costs in connection with my carriage.

(Where needed, to be read by / to the passenger, dated and signed by him / her, of his / her behalf).

Place: _____ Date: _____ Passenger's Signature: _____