



Dear Customer,

Thank you for choosing Lufthansa 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](mailto: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 German Airline, apply.

We wish you a pleasant journey!

Kind regards,

Your

Medical Operation Center



## Information Sheet for Passengers Requiring Special Assistance

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

1.	<b>Name, first name:</b>		Title	Age	Gender	
	Telephone:		Height	Weight		
	E-mail:					
2.	<b>Booking reference (PNR):</b>					
3.	<b>Routing from</b>	<b>To</b>	<b>Flight number</b>	<b>Class</b>	<b>Date</b>	
4.	<b>Type of disability or required assistance:</b>					
5.	<b>Is the patient able to sit in a normal aircraft seat with seatback placed in the upright position?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
6.	<b>Stretcher transport required?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
	<input type="checkbox"/> 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.	<b>Is the patient fit to travel unaccompanied and can he/she take care of all their needs onboard?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
	<b>Is an escort necessary for this journey?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
	Escort (name):		PNR			
	Medical qualification		<input type="checkbox"/> Physician	<input type="checkbox"/> Nurse/paramedic	<input type="checkbox"/> none	
8.	<b>Wheelchair or assistance for boarding required?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
	<input type="checkbox"/> 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.				
	<input type="checkbox"/> 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.				
	<input type="checkbox"/> WCHC	Non-ambulant: Needs assistance in the aircraft to/from seat, toilets and possibly with meals.				
	<input type="checkbox"/> WCH OWN (own wheelchair)	<input type="checkbox"/> WCH BW (wet cell battery)	<input type="checkbox"/> WCH BD (dry cell battery)	<input type="checkbox"/> WCH LB (Li-battery)	<input type="checkbox"/> WCMP (manual)	
	Battery capacity (Wh):		Weight:		<input type="checkbox"/> collapsible	
Dimensions/size (cm):						
9.	<b>Transport from/to airport by ambulance required?</b> (to be arranged by passenger/assistance/insurance)		<input type="checkbox"/> yes	<input type="checkbox"/> no		
	Departure	Company:				
		Contact (telephone/e-mail):				
	Arrival	Company:				
Contact (telephone/e-mail):						
10.	<b>Assistance at the airport required?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
Please specify:						
11.	<b>Other ground arrangements needed?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
Please specify:						
12.	<b>Special in-flight arrangements needed?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
Please specify (e.g. extra seat, medical equipment, etc.):						
Technical clearance by airline granted?						
13.	<b>Frequent Medical Traveller Card (FREMEC) available?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		
	Valid until:		Issued by:			
	<b>FREMEC issuance requested?</b>		<input type="checkbox"/> yes	<input type="checkbox"/> no		



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



## 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

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



## 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 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 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](http://www.lufthansa.com/de/en/information-on-data-protection)

Data protection officer:	Corporate data protection officer Deutsche Lufthansa AG E-Mail: <a href="mailto:datenschutz@dlh.de">datenschutz@dlh.de</a>
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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](mailto: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.

(\*) Regulatory Authority: Hessische Beauftragte für Datenschutz und Informationsfreiheit, Gustav-Stresemann-Ring1, 65189 Wiesbaden – Email: [poststelle@datenschutz.hessen.de](mailto:poststelle@datenschutz.hessen.de)

I agree to the above mentioned data processing.