Physician Authorization
Child Patient

Rev 4/17

TO BE PRE-POPULATED BY ANGEL FLIGHT

To _____ (Authorizing Physician Name)

_____("Patient") has requested an Angel Flight Soars mission flight

and requires transportation from _____ (City) to_____ (City)

for appointment at _____(Medical Facility name

The patient/guardian has given the following reason(s) and has been pre-qualified to have an Angel Flight mission coordinated on their behalf:

____ The necessary medical care/ second opinion/ specialist is not available locally
_____ Car travel is too difficult / time consuming
____ Patient/Guardian cannot afford alternative travel costs
____ Patient is not able to travel on public transportation due to condition / immune deficiency

TO BE COMPLETED BY THE AUTHORIZING PHYSICIAN

I _____ (Authorizing Physician Name), understand that Angel Flight Soars is a nonprofit that coordinates free air transportation with volunteer pilots in privately owned general aviation airplanes. These are typically four to six seat airplanes and are unpressurized but do not fly at altitudes needing supplemental oxygen.

I agree that the above Patient:

- has a legitimate medical appointment that is not available locally
- is able to walk on his/her own power, climb into a private aircraft, and sit upright for extended periods of time
- is currently in and is expected to be in a stable medical condition, not requiring specific or acute medical care during transportation
- is non-contagious

This Authorization is good for:

____ This flight only

____1 year from execution date

Today's Date: _____

_____ _____

Authorizing Physician name (Please print) Authorizing Physician Signature

Address: _____ Telephone: _____

_____ Email: _____

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