



**Physician Authorization Letter
Adult Patient**

Dear Angel Flight of Georgia,

_____ ("Patient") is in my care and requires transportation from _____ to _____.

I agree that the Patient:

- 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; and
- has a legitimate medical appointment that is not available locally.

I understand that the volunteer pilots of Angel Flight of Georgia provide free air transportation in privately owned general aviation airplanes and that these airplanes (which are typically unpressurized) could fly at altitudes as high as 10,000 feet without a need for supplemental oxygen.

I further certify that:

___ Car travel is too difficult/time consuming

___ Patient/Guardian can not afford alternative travel costs

___ Patient is not able to travel on public transportation due to condition

___ Other _____

This Authorization is good for:

___ This flight only.

___ 1 year from execution date.

DATE: _____

Physician name (Please print)

Physician Signature

Address: _____

Telephone: _____