



Physician Authorization Letter Child Patient

Rev 11/11

Dear Angel Flight Soars,

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

I agree that the Patient:

- 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 Soars provide free air transportation in privately owned general aviation airplanes and that these airplanes (which are typically unpressurized) do not fly at altitudes needing supplemental oxygen.

I further certify that:

- ___ 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
- ___ Other _____

This Authorization is good for:

- ___ This flight only.
- ___ 1 year from execution date.

Today’s Date: _____

Physician name (Please print)

Physician Signature

Address: _____

Telephone: _____