Follow this instructions to complete the MEDIF:

1. To start the procedure, make sure that you have a booking on an Aerolineas Argentinas .
2. Complete the MEDIF's form (4 pages)

   Attachment A (1 page): to be completed and signed by passenger or adult in charge.
   Attachment B (part 1 & 2, 3 pages): must be completed, signed and stamped by your doctor.
3. Send the completed form by email to **producto@aerolineas.com.ar**
4. Contact us +54 11 2821-2531 from Monday to Friday from 9am to 9pm, to confirm that your email was received.
5. We will contact you to inform the results of MEDIF's evaluation.
6. On the day of your flight you must bring the original MEDIF and 2 copies, one to be handed in to the check in staff and the other one to the flight attendants.

Useful information:

We kindly ask you to fill in all the blanks in the MEDIF and in print letters.

The MEDIF must be sent at the latest 20 working days before and at least 72 working hours before the flight departure time.

We recommend your Doctor to attach all the relevant case information (clinical history, medical tests, etc.).

The Grupo Aerolíneas Medical Department may request additional information.

"We inform you that the personal information provided in the standard medical information form for air travel (MEDIF) shall be used by Aerolíneas Argentinas S.A. pursuant to the Argentine Personal Data Protection Regulations (Law 25326) and the General Data Protection Regulation of the European Union (2016/679).
The aim of this document is to allow the medical team of Aerolíneas Argentinas to assess the convenience of the passenger's trip, tending to his/her individual health conditions, and if needed, to provide relevant medical assistance. The legal basis for this treatment is your consent; please be aware that you will be asked to provide sensitive information in this form.
The information provided may be shared with third parties in order to ease your trip and provide you with adequate assistance, being this information necessary for such purposes.
The information will be kept for as long as necessary to fulfill the purpose for which it was collected, and to deal with the obligations that may arise from it. At any time, you will be able to exercise your rights of access or objection to, and/or rectification, deletion, portability or restriction of such information, by writing to Aerolíneas Argentinas España or by sending an email to personaldata@aerolineas.eu You must include a copy of your ID or similar official document for identification purposes.
We also inform you that you may turn to the Supervisory Authority in order to enforce your data protection rights.
Find more information on our Privacy Policy at www.aerolineas.com"

Thank you for choosing us!

MEDIF ATTACHMENT A

AerolíneasArgentinas

Reso IATA 700

Information Sheet for the Passengers Requiring Assistance
Please fill out in clear and legible printing. mark an **X** in the corresponding boxes for your answer(s)

1 LAST NAME / FIRST NAME

2 PASSENGER NAME RECORD (6 LETTERS) * → PROPOSED ITINERARY

3 **OUTBOUND** FLIGHT NUMBER AR — DATE (of flight) — FROM: — TO:

CONNECTING FLIGHT NUMBER AR — DATE (of flight) — FROM: — TO:

RETURN FLIGHT NUMBER AR — DATE (of flight) — FROM: — TO:

4 PASSENGER CONDITION:

5 STRETCHER NEEDEDE ON BOARD (NOT AVAILABLE) : Aerolíneas Argentinas **DOES NOT** TRANSPORT PASSENGERS ON STRETCHER

6 INTENTED ESCORTS NO Yes → *PASSENGER NAME RECORD (6 LETTERS) (* IF IT'S DIFERENT) AGE

LAST NAME / FIRST NAME

7 WHEELCHAIR NEEDED ?

WCHR Need a WheelChair to move througth the airport / **can** climb stairs.....

WCHS Need a WheelChair to move througth the airport / **can't** climb stairs.....

WCHC Need a WheelChair up to the seat on the plane.....

OWN WHEELCHAIR ?

NO Yes → CONTINUE

Please cross out not applicable options

° TYPE OF PERSONAL WHEELCHAIR

MANUAL COLLAPSIBLE BATTERY → CONTINUE

° BATTERY TYPE:

**WET (WCBW) *GEL/DRY (WCBD) *LITHIUM (WCLB)

** It is not accepted as luggage, only as cargo.
* The passenger should complete the "Battery powered wheelchair statement " (Attachment C, Chapter 7 M.C.)

8 AMBULANCE NEEDED : **DOES NOT** APPLY INSIDE THE AIRPORT.

9 MEET and ASSIST : DIFFERENT TO THE SERVICE PROVIDED BY Aerolíneas Argentinas WHEELCHAIR **DOES NOT** APPLY

10 OTHER GROUND ARRANGEMENTS NEEDED ? NO Yes

DEPARTURE AIRPORT, Specify :

TRANSIT AIRPORT, Specify :

ARRIVAL AIRPORT, Specify :

11 SPECIAL INFLIGHT ARRANGEMENTS NEEDED ? NO Yes → Specify :

12 FREQUENT TRAVELER MEDICAL CARD "FREMEC" EMITED BY Aerolíneas Argentinas ?

NO Yes → COMPLET → NUMBER OF FREMEC CARD — VALID UNTIL — AGE — SEXO M F

PASSENGER AFFIDAVIT A, The undersigned _____ domiciled at _____ acting on his/her own behalf or on behalf of the above named passenger, hereby states that he or she releases Aerolíneas Argentinas S.A.and its agents and employees from any liability arising from the alteration or deterioration of the passenger's health, serious injuries or any other consequence that could affect the passenger due to his or her health condition during or as a consequence of the flight arranged in the passenger's electronic ticket . Furthermore the undersigned undertakes to reimburse Aerolíneas Argentinas for any expenses incurred in connection with the provision of auxiliary services in addition to the air trasportation service offered by the carrier and, therefore, releases the above mentioned carriers from any liability and/or payment of fees that may arise as a result of any additional services or assistance provided.

/ /

Place & Date — .I.D./Passaport — Passenger Signature

MEDIF ATTACHMENT B (Part1 /veneer 1)

AerolíneasArgentinas

RESO IATA 700

Information sheet for passengers requiring medical clearance, to be completed by the attending physician. Please fill out in clear and legible printing. Mark with an **x** the boxes that correspond.

MEDA 1

PATIENT'S NAME

DATE OF BIRTH GENDER M F HEIGHT WEIGTH

MEDA 2

ATTENDING PHYSICIAN

CONTACT TELEPHONE (indicate country and area code)

E-MAIL Address

MEDA 3

DIAGNOSIS (including date of onset of current illness, episode or accident and treatment) :

IS IT A CONTAGIOUS OR TRANSMISSIBLE DISEASE ? No Yes Date of initation: _____/_____/_____

CAN THE PASSENGER USE THE SEAT IN AN UPRIGHT POSITION WHEN REQUIRED ? No Yes

DOES THE PASSENGER NEED THE USE OF ANY SUPPORT / FASTENER SYSTEM IN THE SEAT TO KEEP THE TORSO IN UPRIGHT POSITION ?

No Yes HARNESS POSTURAL CHAIR

NATURE AND DATE OF ANY RECENT AND/OR RELEVANT SURGERY Date: ____/____/____

MEDA 4

CURRENT SYMPTOMS AND SEVERITY :

MEDA 5

WILL A 25% TO 30% REDUCTION IN THE AMBIENT PARTIAL PRESSURE OF OXYGEN (RELATIVE HYPOXIA) AFFECT THE PASSENGER'S MEDICAL CONDITION? (CABIN PRESSURE BE THE EQUIVALENT OF A MOUNTAIN ELEVATION OF 8000 FEET -2400 METERS- ABOVE SEA LEVEL).

No Yes

MEDA 6

ADDITIONAL CLINICAL INFORMATION:

A- HEMATOLOGIC CONDITION

ANEMIA: No Yes If yes, give recent result in grams of hemoglobin Date: ____/____/____

- Is, the patient under anticoagulant treatment for any reason? No Yes

B- PSYCHIATRIC AND SEIZURE DISORDER ?

No Yes

C- CARDIAC CONDITION

No Yes

D- NORMAL BLADDER CONTROL?

No Yes If no, give mode of control

E- IS THE PATIENT ON DIALYSIS TREATMENT ?

No Yes If yes, please attach the laboratory results after the last dialysis performed.

F- NORMAL BOWEL CONTROL?

No Yes

G- DOES THE PATIENT HAVE A SPECIAL RESPIRATORY CONDITION ?

No Yes

H- DOES THE PATIENT USE OXYGEN AT HOME ?

No Yes If yes, specify how much, amount and time of autonomy in hours without oxygen ?

I- DOES THE PATIENT PLAN TO USE HIS / HER OWN PORTABLE OXYGEN CONCENTRATOR ON BOARD ?

No Yes If yes, specify : BRAND: MODEL:

J- DOES THE PATIENT TRAVEL WITH OTHER RESPIRATORY ASSISTANCE MEDICAL DEVICES THAT WILL USE IN FLIGHT ?

No Yes If yes, specify : **CPAP** **BIPAP** **VPAP** **APAP** **EPAP**

IMPORTANT : duration of the battery/ies in hours:

- FOR FLIGHTS OF LESS THAN 6 HOURS: AUTONOMY EQUAL TO 3 ADDITIONAL HOURS TO THE TOTAL LENGTH OF THE ITINERARY, INCLUDING STOPOVERS AND CONNECTIONS.
- FOR FLIGHTS OF MORE THAN 6 HOURS: AUTONOMY EQUAL TO 150% OF THE TOTAL LENGTH OF THE ITINERARY, INCLUDING STOPOVERS AND CONNECTIONS.

Continue in next page ▶▶

ATTACHMENT B (Part 1 / veneer 2)

AerolíneasArgentinas

Continuation Information sheet for passengers requiring medical clearance, to be completed by the attending physician. Please fill out in clear and legible printing. Mark with an **x** the boxes that correspond.

MEDA **7**

ESCORT

A- IS THE PATIENT FIT TO TRAVEL UNACCOMPANIED ? No ☐ Yes ☐

B- IF NO, WOULD A MEET AND ASSIST (PROVIDED BY THE AIRLINE TO EMBARK AND DISEMBARK), BE SUFFICIENT ? No ☐ Yes ☐

C- IF NO, WILL THE PATIENT HAVE A PRIVATE ESCORT TO TAKE CARE OF HIS/HER NEEDS ON BOARD ? No ☐ Yes ☐

D- IF YES, WHO SHOULD ESCORT THE PASSENGER ? *NURSE* ☐ *DOCTOR* ☐ *OTHER* ☐ _____

E- IF OTHER, IS THE ESCORT FULLY CAPABLE TO ATTEND TO ALL THE ON BOARD NEEDS ? No ☐ Yes ☐

MEDA **8**

MOBILITY

A-CURRENTLY HAVE A BONE FRACTURE : (* if yes, see Part 2) No ☐ Yes ☐

B- ABLE TO WALK WITHOUT ASSISTANCE : No ☐ Yes ☐

C- WHEELCHAIR REQUIRED FOR BOARDING : No ☐ Yes ☐ *

(* IF YES) TO AIRCRAFT : No ☐ Yes ☐ TO SEAT : No ☐ Yes ☐

MEDA **9**

MEDICATION LIST

LIST OF MEDICATION OF THE PATIENT AND FORM OF ADMINISTRATION (UNDER THE SOLE RESPONSIBILITY OF THE PATIENT / COMPANION)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Note: _____

MEDA **10**

ADDITIONAL MEDICAL INFORMATION ABOUT PATHOLOGY, COMORBIDITIES, USE OF PROBES, CATHETERS OR OTHER DEVICES AND / OR CONDITIONS THAT MAY BE RELEVANT DURING AIR TRANSPORT.

NOTE : Cabin attendants are not authorized to give special assistance (e.g. lifting) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in first aid and are not permitted to administer any injection, or to give medication. **Important**: Fees, if any, relevant to the provision of the above information and form carrier-provided special equipment are to be paid by the passenger concerned.

_____ / / _____

Place / Date **PHYSICIAN SIGNATURE**

MEDIF ATTACHMENT B (Part 2)

AerolíneasArgentinas

▶ RESO IATA 700

Information sheet for passengers requiring medical clearance, to be completed by the attending physician. Please fill out in clear and legible printing. Mark with an **x** the boxes that correspond.

MEDA **1**

CARDIAC CONDITION

A- ANGINA No ☐ Yes ☐ ▶ IF YES, WHEN WAS THE LAST EPISODE? _____/_____/_____ IS THE CONDITION STABLE? No ☐ Yes ☐

FUNCTIONAL CLASS OF THE PATIENT → NO SYMPTOMS ☐ ANGINA WITH LIGHT EFFORTS ☐ ANGINA WITH IMPORTANT EFFORTS ☐ ANGINA AT REST ☐

CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WITHOUT SYMPTOMS? No ☐ Yes ☐

B- MYOCARDIAL INFARCTION No ☐ Yes ☐ ▶ DATE: _____/_____/_____ COMPLICATIONS? No ☐ Yes ☐ → (*IF **YES**, GIVE DETAILS)

* _____

STRESS EKG DONE? No ☐ Yes ☐ ▶ IF **YES**, WHAT WAS THE RESULT? _____ METZ.

* IF ANGIOPLASTY OR CORONARY BYPASS, CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB *10-12* STAIRS WITHOUT SYMPTOMS? No ☐ Yes ☐

C- CARDIAC FAILURE No ☐ Yes ☐ ▶ WHEN WAS LAST EPISODE? _____/_____/_____ IS CONTROLLED WITH MEDICATION ? No ☐ Yes ☐

FUNCTIONAL CLASS OF THE PATIENT → NO SYMPTOMS ☐ SHORTNESS OF BREATH: WITH IMPORTANT EFFORTS ☐ WITH LIGHT EFFORTS ☐ BREATH AT REST ☐

D- SYNCOPE No ☐ Yes ☐ ▶ WHEN WAS LAST EPISODE? _____/_____/_____ INVESTIGATIONS ? No ☐ Yes ☐ ▶ (* IF **YES**, STATE RESULTS)

* _____

MEDA **2**

CHRONIC PULMONARY CONDITION No ☐ Yes ☐

A- HAS THE PATIENT HAD RECENT ARTERIAL GASES? No ☐ Yes ☐ ▶

B- BLOOD GASES WERE TAKEN ON: ROOM AIR ☐ OXIGEN ☐ LPM ☐

F YES, WHAT WERE THE RESULTS: **PCO2** _____ **PO2** _____

SATURATION _____ DATE OF EXAM : _____/_____/_____

C- DOES THE PATIENT RETAIN CO2? No ☐ Yes ☐ ▶

D- ¿HAS HIS/HER CONDITION DETERIORATED RECENTLY? No ☐ Yes ☐ ▶

E- ¿PAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WHITHOUT SYMPTOMS? No ☐ Yes ☐ ▶

F- HAS THE PATIENT EVER TAKEN A COMMERCIAL AIRCRAFT IN THESE SAME CONDITIONS? No ☐ Yes ☐ → DATE : _____/_____/_____

DID THE PATIENT HAVE ANY PROBLEMS? _____

MEDA **3**

PSYCHIATRIC CONDITIONS

A- IS THERE A POSSIBILITY THAT THE PATIENT WILL BECOME AGITATED DURING FLIGHT? No ☐ Yes ☐

B- HAS HE/SHE TAKEN A COMMERCIAL AIRCRAFT BEFORE? No ☐ Yes ☐ → DATE : _____/_____/_____

DID THE PATIENT TRAVEL : ALONE ☐ ESCORTED ☐

MEDA **4**

SEIZURE No ☐ Yes ☐ ▶

A- WHAT TYPE OF SEIZURE? _____

B- FREQUENCY OF THE SEIZURES _____ WHEN WAS THE LAST SEIZURE? _____/_____/_____

C- ARE THE SEIZURES CONTROLLED BY MEDICATION? No ☐ Yes ☐

MEDA **5**

PROGNOSIS FOR THE TRIP: GOOD ☐ REGULAR ☐ BAD ☐

MEDA **6**

MOBILITY AND LOCOMOTOR SYSTEM

SPECIFY FRACTURED BONE _____

DATE OF THE FRACTURE _____/_____/_____

IS CURRENTLY PLASTERED? No ☐ Yes ☐ → WHEN WAS IT PLASTERED? _____/_____/_____

IS THE PLASTERED SPLIT? No ☐ Yes ☐

NOTE : Cabin attendants are not authorized to give special assistance (e.g. lifting) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in first aid and are not permitted to administer any injection, or to give medication. **Important**: Fees, if any, relevant to the provision of the above information and form carrier-provided special equipment are to be paid by the passenger concerned.

_____ _____/_____/_____ _____

Place and Date **PHYSICIAN SIGNATURE**