Follow this instructions to complete the MEDIF:

1. To start the procedure, make sure that you have a booking on an Aerolíneas Argentinas or Austral flight.

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.

Thank you for choosing us!
## MEDIF ATTACHMENT A

**Reso IATA 700**

Information Sheet for Passengers Requiring Assistance

Please fill out in clear and legible printing. Mark an "x" in the corresponding boxes for your answer(s).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>LAST NAME / FIRST NAME</strong></td>
</tr>
<tr>
<td><strong>2</strong></td>
<td><strong>Passenger Name Record (6 letters)</strong></td>
</tr>
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<tr>
<td><strong>3</strong></td>
<td><strong>Outbound Flight Number</strong>&lt;sup&gt;AR/AU&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>Date (of flight)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>From:</strong></td>
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<td></td>
<td><strong>To:</strong></td>
</tr>
<tr>
<td><strong>4</strong></td>
<td><strong>Connecting Flight Number</strong>&lt;sup&gt;AR/AU&lt;/sup&gt;</td>
</tr>
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<td><strong>Date (of flight)</strong></td>
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<td></td>
<td><strong>From:</strong></td>
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<td></td>
<td><strong>To:</strong></td>
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<tr>
<td><strong>5</strong></td>
<td><strong>Return Flight Number</strong>&lt;sup&gt;AR/AU&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td><strong>Date (of flight)</strong></td>
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<td></td>
<td><strong>From:</strong></td>
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<tr>
<td></td>
<td><strong>To:</strong></td>
</tr>
<tr>
<td><strong>6</strong></td>
<td><strong>Passenger Condition</strong></td>
</tr>
</tbody>
</table>

- **Stretcher Needed on Board** (Not available; Aerolíneas Argentinas does not transport passengers on stretcher)

- **Intended Escorts**
  - **Yes:**
  - **Passenger Name Record (6 letters)**
  - **Age:**

<p>| | |</p>
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</thead>
<tbody>
<tr>
<td><strong>7</strong></td>
<td><strong>Wheelchair Needed:</strong></td>
</tr>
</tbody>
</table>
|  | **WCHR:** Need a wheelchair to move through the airport / can climb stairs
|  | **WCHS:** Need a wheelchair to move through the airport / can’t climb stairs
|  | **WCHC:** Need a wheelchair up to the seat on the plane

- **Own Wheelchair:**
  - **Yes:**

- **Type of Personal Wheelchair:**
  - **Manual**
  - **Collapsible**
  - **Battery**

- **Battery Type:**
  - **Wet (WCW)**
  - **Gel/Dry (WCBD)**
  - **Lithium (WCLB)**

**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?

- **Yes:**

<p>| | |</p>
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<tbody>
<tr>
<td><strong>Departure Airport, Specify</strong></td>
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<td><strong>Transit Airport, Specify</strong></td>
<td></td>
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<tr>
<td><strong>Arrival Airport, Specify</strong></td>
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</tbody>
</table>

**11** Special Inflight Arrangements Needed?

- **Yes:** Specify

**12** Frequent Traveler Medical Card (FREMEC) Emited by Aerolíneas Argentinas?

- **Yes:**

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</table>
| **Passenger Affidavit:** 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 Austral Lineas Aéreas Ciezas del Sur 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 transportation 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**

**Revision 2 - Sep. 2019**
MEDIF ATTACHMENT B (Part 1/veneer 1)

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

WEIGHT

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 initiation: __/__/__

 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 2400 METERS (8000 FEET) 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.
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 ✗ the boxes that correspond.

**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 □]

**Mobility**

A- Currently have a bone fracture:  [No □ Yes □] (* if yes, see Part 2)

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 □]

**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: ____________________________

**Additional Medical Information About Pathology, Comorbidities, Use of Probes, Catheters or Other Devices and/or Conditions that May Be Relevant During Air Transport.**

[Blank space]

[Blank space]

[Blank space]

[Blank space]

[Blank space]

[Blank space]

[Blank space]

Place / Date: ____________________________

PHYSICIAN SIGNATURE: ____________________________

Revision 2 - Sep. 2019
### Cardiac Condition

| A. Angina | 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**
- Yes | Date: | Complications?
- No | Yes | (If yes, give details)

**Stress EKG done?**
- No | Yes | IF YES, WHAT WAS THE RESULT? | 

* 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**
- Yes | WHEN WAS THE LAST EPISODE? | IS IT 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**
- Yes | WHEN WAS THE LAST EPISODE? | IS IT CONTROLLED WITH MEDICATION? | No | Yes | (If yes, state results)

### Chronic Pulmonary Condition

| A. Has the patient had recent arterial cases? | Yes |
| B. Blood cases were taken on | Room Air | Oxygen | LPM |
| F. Yes, what were the results: PO2 | PCO2 | Saturation | DATE OF EXAM |

**C. Does the patient retain CO2?**
- No | Yes

**D. Has his/her condition deteriorated recently?**
- No | Yes

**E. Can the patient walk 100 meters at a normal pace or climb 10-12 stairs without symptoms?**
- No | Yes

**F. Has the patient ever taken a commercial aircraft in these same conditions?**
- Yes | DATE: |

**DID THE PATIENT HAVE ANY PROBLEMS?**

### Psychiatric Conditions

| A. Is there a possibility that the patient will become agitated during flight? | Yes |
| B. Has he/she taken a commercial aircraft before? | Date: |

**DID THE PATIENT TRAVEL:**
- Alone | Escort

### Seizure

| A. What type of seizure? |
| B. Frequency of the seizures | WHEN WAS THE LAST SEIZURE? |
| C. Are the seizures controlled by medication? | No | Yes |

### Prognosis for the Trip

- Good | Regular | Bad

### Mobility and Locomotor System

| Specify fractured bone |
| Date of the fracture |
| Is currently plastered? | Yes |
| Is the plastered split? | No |

**Place and Date**
- Revision 2 • Sep.2019

**Physician Signature**