Medical Verification Statement: C/PAP and Bi/PAP Machines

This document serves as verification that ……………………………requires the use of a -

- Continuous Positive Airway Pressure Machine
- Bi-Level Positive Airway Pressure Machine

I verify the following:

- That the passenger has the physical and cognitive ability to see, hear and understand the device, and is able without assistance, to operate this device.
- That the passenger is not able to operate the device but is accompanied by a passenger who familiar with, and is able to operate this device.
- The passenger does not require on board oxygen for travel
- The passenger requires oxygen for travel 2 litres……….. 4litres………..

If on board oxygen is required for travel, a MEDIF form will need to be completed in addition to this form, indicating stability of respiratory condition as well as indication of current oxygen saturation reading on room air.

The requirement for the use of the C/PAP or BI/PAP on board is as follow: (Mark requirement that specifically applies for use on board)

- Continuous – During all phases of the flight, including takeoff and landing
- Intermittent – During the flight, but not whilst taxing, take off and landing.

I, Dr………………………….. Hereby certify that the above named passenger is under my care and in my opinion may travel on board a commercial aircraft without the likelihood of risk to their health or physical condition

My patient understands that it is their sole responsibility to provide batteries, masks and all other device related equipment, and that the airline shall take no responsibility for the physical condition of the machine. In addition, I have advised the passenger to carry ample charged batteries to power the device for the duration needed on the flight, as well as for 3 additional hours to cover any unexpected delays.

The passenger’s physical condition is stable, and it is not anticipated that this passenger will require any specialized medical assistance on board
Any change to the patient’s health that would amend the criteria listed above, will require and updated Physician’s Medical Verification Statement to be completed.

Please ensure that device is dry cell battery operated as no device requiring power from the aircraft will be accepted.

Physician’s signature…………………………DEA…………Address…………………………

Office contact number……………………Date……………………