porter

FORM C – page 1

REQUEST TO OPERATE PORTABLE OXYGEN CONCENTRATOR

In compliance with SFAR 106, passengers who require use of a portable oxygen concentrator onboard a Porter Airlines aircraft must provide a written statement signed by a licensed physician and containing the information shown on page 2 of this document. The Physician's Statement is valid for one (1) year from the date of signature.

Please complete and submit this document together with the Physician's Statement and any reservation details to Porter by fax at **416 203 6422** as far in advance of the date of intended travel. If submitted within 48 hours, we will make every reasonable effort to accommodate the request.

Fees incurred for the completion of this document are the responsibility of the passenger. Incomplete or illegible documents will not be approved. Passengers must present the completed Physician's Statement to airline representatives upon check-in.

Porter reserves the right to contact the passenger's physician to confirm or clarify details contained within. Medical information shared will be kept confidential in accordance with PIPEDA and CTA requirements.

Portable oxygen concentrators must be certified as RTCA/DO-160F, Section 21, Category M compliant. Porter Airlines allows the use of AirSep Freestyle, AirSep Lifestyle, Inogen One, Inogen One G2, SeQual Eclipse, Respironics EverGo, Delphi RS-00400 (EVO Central Air), DeVilbiss iGo, Invacare XP02, Invacare Solo2, Oxlife Independence and International Biophysics LifeChoice portable oxygen concentrators aboard its aircraft. Portable oxygen concentrators must fit under a passenger seat in a space measuring 17 inches deep by 15 inches wide by 8.5 inches in height.

Passengers are responsible for ensuring that their portable oxygen concentrator is in good condition, free from contamination such as oil or grease, and shows no visible signs of damage or abuse.

Passengers are responsible for ensuring that they carry sufficient batteries to provide an adequate supply of oxygen for the duration of their travel time including flight, all ground time and any unexpected delays. Batteries must be transported in carry-on baggage and packaged in a manner that protects them from damage or short circuit.

Please visit www.flyporter.com for details of services available to passengers with disabilities.

Passenger Name: _____

Address: _____

Telephone: _____ **Email Address:** _____

Birthdate dd/mm/yyyy**:**_____ **Gender:** **Male** ☐ **Female** ☐

Date of Travel dd/mm/yyyy**:** _____ **To/From:** _____

Proposed Flight(s): _____ **Reservation Number:** _____

Type of POC proposed for use aboard: _____

Dimensions of POC: _____

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Passenger Consent

I hereby authorize Dr. _____ to provide and discuss information requested in this document to Porter.

Signature: _____ *Name:* _____
(Please print)

PHYSICIAN'S STATEMENT

Name of Patient: _____

Address: _____

_____

1. Does the patient named above have the physical and cognitive ability to see, hear, and understand aural and visual cautions and warnings associated with their portable oxygen concentrator (POC), and respond accordingly without assistance?

Yes: ☐ No: ☐

If no, the user must travel with a companion who is capable of performing these functions on their behalf.

2. Is oxygen use medically necessary for all or a portion of the duration of the trip?

All: ☐ Portion: ☐

If necessary for a portion of the flight only, please specify:

3. Under normal operating conditions, the pressure of the aircraft cabin equals 8,000 feet above sea level. Given this cabin pressure, what is the maximum flow rate required by the user?

_____

By signing this document, I understand that I am providing information which will be used to determine that the patient can safely travel aboard a Porter flight with the use of a POC. If I have indicated that the patient cannot respond appropriately to the cautions and warnings of the POC, I am acknowledging that the patient must travel with a companion who is capable of performing these functions on their behalf.

I thereby certify that the information provided in this document is correct and accurate to the best of my knowledge.

Name of Physician: _____ **Telephone Number** _____

Signature of Physician: _____ **Date:** _____

Province of Registration: _____ **Current Registration Number:** _____