Oxygen Cylinder Check Form

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Cylinder Requirement for Carry-on or Checked Baggage	①Cylinder must not exceed 5kg gross weight ②Cylinder must be Medical Oxygen Cylinder filled with oxygen or air. ③Cylinder must be within validity period ④ Cylinder must be 70cm or less in length and 10cm or less in diameter.
Passenger Name	Name :
Flight numbe Date of boarding	【Outbound】Flight NO DATE : 【Inbound】Flight NO : DATE :
Product Name / Size	Product Name : Weight : kg *For csrry on must be 5kg or less due to Civil Aeronautic Law in Japan Length cm x Length cm *Sum of 3 sides must be 203 cm for check in
How to store inside cabin	・Cylinder must be stowed under the passenger seat ・Any cylinder that cannot be stowed under the passenger seat must be tied-down in an adjacent seat, for which you will be charged.
Number of cylinders	【Outbound】Carry-on + Checked = Total 【Inbound】Carry-on + Checked = Total
Check list for the cylinders	＜ Choose Either ＞ ＜Cylinder Number＞ ＜Date of next inspection＞ ☐Outbound ☐Inbound Checked DATE Checked ☐Outbound ☐Inbound DATE ☐ It is an approved cylinder and labeled ☐ It is gaseous oxygen for medical purposes only, labeled "O2." ☐It must have passed a stress test within the last 3 years (5 years for some cylinders). ☐Container made of fiberglass (Fiber Reinforced Plastics) must not lapsed 15 years after manufacturing.
Name registrant	Company Date Name NAME Telephone

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MEDICAL INFORMATION FORM (MEDIF)

To be completed by Doctor

The attending physician is requested to answer all questions. Enter a check mark(✔) in the appropriate "Yes" or "No" boxes, and/or give precise and concise answers.

●Note 1 Please write so that non-medical personnel are able understand.

●Note 2 Cabin Attendants are not authorized to provide personal care services, such as assistance in using lavatory facilities, with eating and drinking etc. etc.additionally,they are not authorized to administer medical care service

Patient's Information			
Name		Age Gender	
Diagnosis in details ●Note 1			
When did the first symptoms appear (Date of Operation if any)	DATE	For expecting mother (Estimated date of delivery)	

1	Prognosis for the flight(s)	FIT ☐	NOT FIT☐	Prognosis for the Return Flight (if any)	FIT ☐ NOT FIT☐
2	Can the patient use normal aircraft sea with the seatback placed in the Uprigh Position when so required? ※Stretcher is not available	YES ☐	NO ☐		
3	Can the patient take care of his/her personal needs (lavatory, eat, drink etc without assistant?Note 2	YES ☐	NO ☐		
4	Can the patient trave	YES ☐	NO ☐	**If No, Specify name and details of Escort.**	
5	Does the patient need medical equipm in flight? ●Note 2	YES ☐	NO ☐	**If Yes, Specify.** ■The name of Medical Equipment ■Product name/Model number: ■Type of Battery/Size:	
6	Does patient need any medication in flight?	YES ☐	NO ☐	**If Yes, indicate arrangements made**	
7	We would appreciate any general comment about the patient's condition and suggestion for the proposed air travel.				

I will provide necessary information required for the purpose of determining his/her fitness to travel by air as above with consent of the patient.

Doctor

Name(Signature)			Date
Hospital Name		Address	
Telephone Number		Emergency Number	

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Necessary Arrangement Request 【To be completed by the passenger】

Passenger

Name				Age	
				Gender	
Phone Number (Mobile Phone)		Email address			
Iterary	Departure Date:	Flight number:	NQ	from	to
	Departure Date:	Flight number :	NQ	from	to

Escort

Name		☐Physician	☐Nurce	☐Others
Nme		☐Physician	☐Nurce	☐Others

1	1 Do you need wheelchair at the airport？ ☐ No ☐Yes → Category: ☐ Requires assistance to/from the cabin seat. (WCHC) ☐ Cannot ascend/descend steps, but able to walk in the cabin. (WCHS) ☐ Can ascend/descend steps, but requires wheelchair for walking long distance. (WCHR)
2	Are you travelling with your own wheelchair? ☐ No ☐Yes → Wheelchair Size: Weight: kg Width(W): cm Depth(D): cm Height(H): cm Wheelchair Type: *Is the battery Removable? ☐Yes ☐No ☐Manual ☐Collapsible ☐Non-Collapsible ☐Electric/Battery-powered ☐Lithium-ion Battery ☐Dry Battery (NiCad, Ni-MH) ☐Wet Battery(Gel,Sillicon) ☐Non-Spillable Battery ☐Spillable
3	Do you use electric medical device in flight? (POC etc.) No☐ Yes☐→If “Yes”, please inform Contact Center of the details of the electric medical device in advance in order to confirm whether it can be used in flight.

Agreement

I hereby authorize _____ (Name of nominated attending physician)to provide the airlines with the information required by those airline's medical department for the purpose of determining my fitness for carriage by air and in consideration thereof, I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information and agree to meet such physician's fees in connection therewith.

Date _____

Passengers signature: _____
（or a Representative）