

MEDIF: follow these instructions to fill it out

1. Have a booking on a flight operated by Aerolíneas Argentinas.
2. The passenger or adult in charge must fill out the MEDIF form in its entirety and sign it.
3. Send the filled-out form to **producto@aerolineas.com.ar**. In the subject, state: MEDIF + passenger number code (6 letters) + flight date of the first segment. E.g., MEDIF.XPNRUT.06/21/22.
4. We will contact you to inform you about the results of the assessment made by our medical department.
5. On the day of your flight, you must bring the original MEDIF and 3 (three) copies.

USEFUL INFORMATION

Submission of the form: You must submit the MEDIF no later than 20 business days in advance and at least 72 business hours prior to the departure of your flight. Take into consideration that business hours are from Monday to Friday, from 08:00 a.m. to 08:00 p.m., and on Saturdays, Sundays and holidays, from 08:00 a.m. to 02:00 p.m.

We suggest attaching the records that your attending physician considers relevant for the analysis of the case (clinical history summary, results of your last medical tests, etc.). The Medical Department of ARSA may request additional information.

Booster seats or harnesses: check www.aerolineas.com.ar/en-ar/availableservices at least 10 business days in advance for information on the restraint systems accepted on board and the requirements in case of exceptions.

Oxygen concentrator: check www.aerolineas.com.ar/en-ar/availableservices for information on the concentrators that can be used on board.

Required battery autonomy:

- ▶ For flights lasting less than 6 hours (including stopovers and connections): the device must have enough battery power to operate for 3 additional hours to the scheduled flight time. For example: for a 5-hour flight, the battery must have enough power for 3 extra hours, i.e., it must have a battery life of 8 hours as from boarding.
- ▶ For flights lasting more than 6 hours (including stopovers and connections): The device must have a battery autonomy equivalent to 150% of the scheduled flight time. For example: For a flight with a duration of 6 hours and 30 minutes, the battery must have enough power for 9 hours and 45 minutes as from boarding.

Transport of peritoneal dialysis solution: contact **producto@aerolineas.com.ar** at least 20 business days before the departure of your flight. In the case of international flights, contact the consulate/embassy of your destination to learn about the customs and migration requirements. The potential fees related to customs stages, if any, shall be borne by the passenger. In the case of flights within Argentina, temperature restrictions in the hold may apply.

Medication: the passenger is solely responsible for the administration and carriage of his/her medication.

Note: Aerolíneas Argentinas does not carry stretchers on board.

Thank you for flying with us!

"We inform you that the personal information provided in the standard medical information form for air travel (MEDIF), will be processed by Aerolíneas Argentinas S.A. pursuant to the Personal Data Protection Regulations of the Argentine Republic (Law 25326) and the European Union (Reg. 2016/679). The purpose of this document is to allow the medical team of Aerolíneas Argentinas to assess the convenience of the passenger's trip, taking into account his/her specific health conditions, and, if needed, to provide the relevant medical assistance. The legal basis for this treatment is your consent; be aware that you will be asked to provide sensitive information in this form.

The information you provide may be shared with third parties in order to arrange your trip and provide you with adequate assistance, being this information necessary for such purposes.

The data 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: basededatos@aerolineas.com.ar 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".

To be completed by the passenger. Fill out this form in print capital letters and mark the applicable boxes with an x.FIRST AND LAST NAME AGE EMAIL PASSENGER NUMBER CODE (6 letters) OUTBOUND FLIGHT NUMBER DATE FROM TO CONNECTING FLIGHT NUMBER DATE FROM TO RETURN FLIGHT NUMBER DATE FROM TO INTENDED ESCORT: NO ☐ YES ☐ PASSENGER NUMBER CODE (6 letters) AGE FIRST AND LAST NAME **DOES THE PATIENT REQUIRE WHEELCHAIR ASSISTANCE?**NO ☐ YES ☐

If YES, state the type of assistance required:

▶ Wheelchair to move through the airport. The patient can climb or descend stairs. ☐▶ Wheelchair to move through the airport. The patient cannot climb or descend stairs. ☐▶ Wheelchair up to seat on the plane. ☐**PASSENGER SWORN STATEMENT**

The undersigned domiciled at acting on his/her own behalf or on behalf of the passenger, hereby states that he/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, as well as any serious injuries or any other consequence that could affect the passenger due to his/her health condition during or as a consequence of the air carriage, as stated in his/her electronic ticket. Furthermore, the undersigned, in his/her relevant capacity, undertakes to reimburse Aerolíneas Argentinas for any expenses incurred in connection with the provision of any additional services specific to air carriage that may be required, and further releases Aerolíneas Argentinas from any liability and/or payment of fees that may arise as a result of such additional services or assistance. Furthermore, I accept that boarding may be denied by Aerolíneas Argentinas if my health condition does not match the data provided or if, by boarding, I endanger my health, the health of other passengers or the flight operations.

I am aware that passengers requiring assistance and individuals with disabilities and/or reduced mobility will have priority boarding. The Crew Chief/Senior Cabin Crew Member will welcome the passenger and, if necessary, a flight attendant will assist the passenger to board and place his/her hand baggage. Such flight attendant will provide the passenger with individual instructions regarding the emergency procedures and cabin layout (location of lavatories, emergency exits, comfort items, etc.). At the passenger's request, the flight attendant will also assist the passenger by taking him/her to the lavatory in an on-board wheelchair, in wide-body aircraft.

In the event of a medical emergency during the flight, the assistance provided by the Cabin Crew will be limited to basic first aid. In any other situation, the Crew must wait for a qualified person to take action, and they may only observe the evolution of the injured or sick passenger and give him/her comfort and human support to help him/her cope with his/her condition. The Cabin Crew cannot suggest, offer, or administer any medication or food to the sick passenger or apply injections. Escorts must be over 13 years old, be able to communicate with the crew, be in proper physical and psychological condition to assist the passenger during the flight and help him/her evacuate in case of emergency.

Place and date

ID (D.N.I.)/Passport

Signature of the passenger or person in charge

FIRST AND LAST NAME <i>(passenger)</i>	<input type="text"/>	AGE	<input type="text"/>
FIRST AND LAST NAME <i>(physician)</i>	<input type="text"/>		
PHONE NUMBER <i>(with area code)</i>	<input type="text"/>		
EMAIL	<input type="text"/>		

M.01 DIAGNOSIS

DATE OF ONSET | | | | | |

NO ☐ YES ☐

NO ☐ YES ☐

DATE | | | | |

M.02 CAN THE PASSENGER USE THE SEAT IN AN UPRIGHT POSITION WHEN REQUIRED?

NO ☐ YES ☐

M.03 DOES THE PASSENGER USE A RESTRAINT SYSTEM?

NO ☐ YES ☐

If YES, indicate which one: HARNESS ☐ CHAIR ☐

M.04 VITAL SIGNS

Blood pressure..... Heart rate..... Oxygen saturation on room air

Other signs you would like to inform:

Physician's signature and seal:

To be completed by the attending physician. Fill out this form in its entirety, in print capital letters, and mark the applicable boxes with an x.

M. 05 HEART CONDITION

 NO ☐ YES ☐

If YES, indicate which one:

IS THE CONDITION STABLE?

 NO ☐ YES ☐
WHEN WAS THE LAST EPISODE?

| | | | | | |

HEART FAILURE

 NO ☐ YES ☐

- ▶ When was the last episode? | | | | | | |
- ▶ Is it controlled with medication? NO ☐ YES ☐
- ▶ Shortness of breath: With important efforts ☐
- With light efforts ☐
- ▶ Functional classification: Symptoms NO ☐ YES ☐
- At rest ☐

MYOCARDIAL INFARCTION

 NO ☐ YES ☐

- ▶ Date: | | | | | | |
- ▶ Complications? NO ☐ YES ☐
- ▶ If YES, indicate which one:
-

ANGINA

 NO ☐ YES ☐

- ▶ With important efforts ☐
- ▶ With light efforts ☐
- ▶ At rest ☐
- ▶ Functional classification: Symptoms NO ☐ YES ☐

SYNCOPE

 NO ☐ YES ☐

- ▶ When was the last episode? | | | | | | |
- ▶ Investigated? NO ☐ YES ☐
- ▶ If YES, please elaborate:
-

CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WITHOUT SHOWING SYMPTOMS?

 NO ☐ YES ☐
M. 06 CHRONIC PULMONARY CONDITION

 NO ☐ YES ☐

If YES, indicate which one:

A. DOES THE PATIENT HAVE THE RESULTS OF STUDIES ON ARTERIAL GASES?

 NO ☐ YES ☐

If YES, indicate the results:

 PCO2 PO2
 Saturation DATE | | | | | | |

Blood gases were taken:

 ON ROOM AIR ☐ WITH SUPPLEMENTARY OXYGEN ☐

 Does the patient retain CO2? NO ☐ YES ☐
B. CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WITHOUT SHOWING SYMPTOMS?

 NO ☐ YES ☐
D. DOES THE PATIENT NEED TO USE HIS/HER OWN PORTABLE OXYGEN CONCENTRATOR ON BOARD?

 NO ☐ YES ☐
C. HAS THE PATIENT EVER TAKEN A COMMERCIAL FLIGHT IN THESE SAME CONDITIONS?

 NO ☐ YES ☐

DATE | | | | | | |

Did the patient have any problems?

 NO ☐ YES ☐

If YES, indicate which one:

E. WILL THE PATIENT USE OTHER RESPIRATORY ASSIST DEVICES DURING THE FLIGHT?

 NO ☐ YES ☐

If YES, indicate which one:

F. CAN REDUCTION IN PARTIAL PRESSURE OF OXYGEN (RELATIVE HYPOXIA) AFFECT THE PATIENT'S MEDICAL CONDITION?

 NO ☐ YES ☐

(cabin pressure is equivalent to being 2,400 meters or 8,000 feet above sea level)

Physician's signature and seal:

To be completed by the attending physician. Fill out this form in its entirety, in print capital letters, and mark the applicable boxes with an x.

M. 07 HEMATOLOGIC DISORDER

 NO ☐ YES ☐

If YES, indicate which one:

A. ANEMIA: NO ☐ YES ☐

If YES, attach recent results of hemoglobin:

..... GR./DL DATE

B. IS THE PATIENT ON DIALYSIS TREATMENT? NO ☐ YES ☐

If YES, please attach the laboratory results after the last dialysis performed.

M. 08 PSYCHIATRIC CONDITIONS

 NO ☐ YES ☐

If YES, indicate which one:

A. IS THERE A POSSIBILITY THAT THE PATIENT'S CONDITION WILL BE AFFECTED DURING THE FLIGHT?

NO ☐ YES ☐

B. HAS HE/SHE TAKEN A COMMERCIAL FLIGHT BEFORE?

NO ☐ YES ☐ DATE

C. DID THE PATIENT TRAVEL: ALONE ☐ ESCORTED ☐

M. 09 SEIZURES

 NO ☐ YES ☐

A. DATE OF THE LAST EPISODE

B. ARE THE SEIZURES CONTROLLED WITH MEDICATION? NO ☐ YES ☐

M. 10 DOES THE PATIENT HAVE MOBILITY AND A PRESERVED LOCOMOTOR SYSTEM?

 NO ☐ YES ☐

If NOT, indicate the reason:

A. HAS THE PATIENT SUFFERED A BONE FRACTURE?

NO ☐ YES ☐ DATE OF THE FRACTURE:

C. IS THE PLASTER CAST SPLIT? NO ☐ YES ☐

B. DOES THE PATIENT CURRENTLY HAVE A PLASTER CAST?

NO ☐ YES ☐ DATE OF APPLICATION:

D. DOES THE PATIENT REQUIRE WHEELCHAIR ASSISTANCE DUE TO THIS SITUATION? NO ☐ YES ☐

M. 11 LIST OF PATIENT'S MEDICATION AND FORM OF ADMINISTRATION

1.
2.
3.
4.
5.
6.

Physician's signature and seal:

To be completed by the attending physician. Fill out this form in its entirety, in print capital letters, and mark the applicable boxes with an x.

M. 12 ESCORT

A. IS THE PATIENT FIT TO TRAVEL UNACCOMPANIED?

NO ☐ YES ☐

B. IF NOT, WHO WILL ESCORT THE PATIENT?

NURSE / PHYSICIAN ☐

OTHER ESCORT ☐

M. 13 MEDICAL INFORMATION

Write a brief summary about any diseases, comorbidities, possible complications, use of probes, catheters, or other devices and/or conditions that may be relevant during air carriage.

M. 14 DOES THE PATIENT REQUIRE A STRETCHER TO ARRIVE AT OR MOVE WITHIN THE AIRPORT?

NO ☐ YES ☐

M. 15 PROGNOSIS FOR THE FLIGHT

GOOD ☐ BAD ☐

M. 16 IS HE/SHE IN PSYCHOLOGICAL AND PHYSICAL CONDITION TO TAKE THE COMMERCIAL FLIGHT? NO ☐ YES ☐

I declare under oath that the information provided in this form is true, having reported all his/her possible medical complications. I further undertake to provide any additional information that may be required. I am aware that the company's physicians may deny boarding if the passenger's condition does not match the data provided or if, by boarding, the passenger endangers his/her health, the health of other passengers or the flight operations.

Place and Date

Physician's signature and seal