Dear Doctor or Medical Professional,

We require your assistance to finalize a request by your patient to travel with Angel Flight South Central for medical treatment at a distant medical facility. We appreciate your help in completing and returning this form at your earliest convenience.

I, ______________________________, hereby confirm that ______________________________
(Physician First, Last Name) *(Patient First, Last Name)*

is a patient in my care who meets the following criteria:

- **Patient is medically stable** to travel in a small, non-pressurized aircraft that typically seats 4-6 passengers. The patient does not have any medical conditions that could affect either the safety of the pilot or the patient's personal health on the flight. These may include, but are not limited to, conditions such as seizures, mental disorders, respiratory issues, or the need for medical care during the flight.
- **Patient is ambulatory** and able to climb in and out of a small plane by stepping up 16 to 20 inches with limited assistance. The patient is also able to sit upright for the duration of the flight. The patient is not more than 20 weeks pregnant.
- **Patient has a legitimate need to travel for medical care.** Our pilots donate their time, skills, and the cost of fuel to provide free transportation for patients who require medical treatment not available to them locally. We need to ensure that our resources are being used by those who truly need them.

Physician Signature: ___________________________________ Date: _________________

Phone: _____________________________________ Fax: _____________________________

Facility Name: ____

Address: ____

Please fax the completed form to 972-858-5492 or email it to coordinator@angelflightsc.org. If you have any questions about our services, please call our office at 972-755-0433. The patient's mission will not be scheduled until we receive this signed letter from you.

Sincerely,

AFSC Mission Coordination Team