



Physician's Letter

Your patient has requested assistance with transportation for his/her medical needs. In order for this to occur, please print your name and sign this form to confirm that this patient can safely fly using our services.

(Patient's Name) _____ is a patient in my care who requires transportation for the following reasons: _____

_____ and is medically stable, ambulatory and physically able to enter and exit a small, light, non-pressurized aircraft (generally 4-6 seats). The patient does not have any medical conditions that could affect either the safety of the flight (taking into account such conditions as seizures and medical disorders or any medical equipment) or his/her personal health during the flight..

Physician Name: (Please type or print) _____ **Date:** _____

Physician Signature: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

**** IS YOUR FACILITY HIPAA COMPLIANT? YES _____ NO _____**

Note to the Physician:

The cabin of a small aircraft can be smaller than the inside of a small vehicle, and in certain aircrafts the passenger will be seating alongside the pilot with close proximity of the flight controls and switches. Your patient should have a legitimate need for medical treatment not available locally and should also need to avoid lengthy surface transportation. Please give Grace Flight up to **7 business days (Monday – Friday)** notice or more to locate volunteer pilots to make the mission; many are business people who must rearrange their schedules to fit the needs of your patient.

***** THIS PAGE MUST BE COMPLETED BY THE PATIENT'S DOCTOR
(not by the patient) & FAXED BACK TO THE OFFICE (972) 858-5492. ****