PREGNANCY FORM

TO WHOM IT MAY CONCERN

Patient Name: _____

Estimated Date of Delivery: ☐☐ / ☐☐ / ☐☐☐☐

Proposed dates of air travel:

DATE	FLIGHT NO.	FROM	TO

Additional Remarks: _____

In my opinion this patient has:

1. A single uncomplicated pregnancy ___ weeks gestation and is fit to travel for the time covering the entire journey, or
2. A multiple uncomplicated pregnancy of ___ weeks gestation and is fit to travel for the time covering the entire journey.

Doctor's / Midwife's Signature: _____

Name and contact of Doctor / Midwife:

_____

_____

_____

Doctor's and/or clinic stamp:

_____

Date: ☐☐ / ☐☐ / ☐☐☐☐

PLEASE PRESENT THIS FORM TO CHECK-IN STAFF ON YOUR DAY OF TRAVEL