

Notice: All passengers requiring respiratory assistive devices in flight must complete **Section 1**. The physician must complete **Section 2**. When **all** fields are completed, fax this request for medical screening to OxygenToGo® at (877) 329-6994 a **minimum of 48 hours** (excluding weekends) prior to the scheduled departure of their first flight. OxygenToGo® will contact the passenger to review and give approval to board. OxygenToGo® is open for calls between the hours of 9:00 a.m. and 8:00 p.m. Eastern Standard Time, Monday thru Friday. **Tanks** of any kind are **not allowed** on board the aircraft.

Note: All fields must be completed and, if approved to board, you must bring a copy of this form with you to the airport.

Only FAA approved Portable Oxygen Concentrators (POC) can be used on board during flight. See the list in **Section 2**. for a list of FAA approved Portable Oxygen Concentrators. For concentrator rental for Delta, contact OxygenToGo® at 866-692-004. You must complete the OxygenToGo® rental agreement in order to be supplied with oxygen from OxygenToGo®. Call 866-692-0040 - www.oxygentogo.com

Section 1. General information to be completed by the passenger, family, or medical staff.

The **total number of batteries** that you have or will be supplied: _____ - **if left blank, you're not approved to board!**
(Note: The FAA requires 150% of flight hours in battery hours.) OxygenToGo® rents batteries via next day courier, if needed.

Name of passenger using the Portable Oxygen Concentrator (POC): _____

Travel Information: Confirmation Number (this will be six (6) digits long) _____ **and** Flight Number(s) & Date of Travel:

Departing Flight #1 _____ Flight #2 _____ Flight #3 _____ Flight #4 _____ Date of departure: ____/____/____ (M/D/Y)

Returning Flight #1 _____ Flight #2 _____ Flight #3 _____ Flight #4 _____ Date of departure: ____/____/____ (M/D/Y)

Passenger's contact phone number (including area code/country code): (____) _____ or (____) _____

Supplier of POC device: Portable Oxygen Concentrator (POC) provided by OxygenToGo® _____
 Customer owned or rented Portable Oxygen Concentrator (POC) _____

Name of POC supplier. **(Leave all blank if OxygenToGo®):** _____ If customer owned check box:

Contact person at : _____ Email (if known): _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Section 2. To be completed by the physician.

Liter(s) Per Minute (LPM) required assuming a cabin altitude of 8,000 ft: _____ LPM (maximum LPM 3 continuous and 5 pulse flow)

(Circle One) **Pulse flow** or **Continuous flow**. **(Definition:** Continuous "use" of oxygen is not Continuous "flow" or "dose" oxygen. Call 866-692-0040 to speak to a licensed Respiratory Therapist)

Make and model of POC (Portable Oxygen Concentrator): (Circle One)

- | | |
|--|--|
| Inogen One (1-5 LPM Pulse only) | Inogen One G2 (1-5 LPM Pulse only) |
| Respironics EverGo (1-6 LPM Pulse only) | LifeChoice (1-3 LPM Pulse only) |
| Invacare XPO2 (1-5 LPM Pulse only) | Delphi RS-0040 (1-5 LPM Pulse only) |
| AirSep Lifestyle (1-5 LPM Pulse only) | AirSep Freestyle (1-3 LPM Pulse only) |
| Sequal Eclipse (1-6 LPM Pulse & 1-3 LPM Continuous flow) | |
| DeVilbiss iGo (1-6 LPM Pulse & 1-3 LPM Continuous flow) | |
| Oxlife Independence (1-6 LPM Pulse & 1-3 LPM Continuous flow) | |
| Invacare Solo2 (1-5 LPM Pulse & 1-3 LPM Continuous) | |

Note: Only Portable Oxygen Concentrators are allowed on board Delta which must medically match patient use for their LPM.

Note: Initial box if oxygen is not needed during the duration of the flight and the POC is carry on only.



I, _____, (MD, DO) licensed to practice medicine in the state of _____, certify that

_____ is a patient under my care. It is my professional judgment that he/she is physically able to complete an airline flight safely without requiring extraordinary medical assistance, even if the flight is of greater length than scheduled, terminates at a point other than the expected destination, or involves other irregular operations.

I further certify that the above-mentioned patient does not have a disease or infection that can be transmissible to other persons during the normal course of the flight.

Signature: _____, MD/DO ____/____/____ (M/D/Y) Email: _____

Print Physician Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____ Fax: (____) _____