Worksheet for Requesting an Mountain Outreach Flights

Date: ______________ Requester: ______________________________ Cell #: ____________________

How did you hear about MOF? Medical Facility_____ Social Service Agency _____ Found on Internet _____
Another Volunteer Pilot Organization _____
Other____

Have you contacted any other Volunteer Pilot Organizations to schedule flights: Yes _____ No: _____

What is your reason for travel: Clinical Trial _____ Cancer _____ Surgical Need _____ Rare Disease _____
Other _________________________

Passenger Name: _____________________________DOB:__________Ht:_____ Wt: _______ Male: ___ Female: ___
Passenger Address: ______________________________________
City/St./Zip:______________________________
Passenger Home Phone:______________________ Cell Phone:_____________________
E-mail Address: ______________________________________Primary Language: English: ____ Other: ___________
Appt. Date: ______________ Time: _____________
Requested Departure Flight Date: __________________ Requested Return Flight Date: __________________
Departure City: _________________________________
Arriving City________________________________
Luggage Description/Weight (MAX 40lbs.) ____
(Please let us know if you need to bring any oxygen devices, medical devices, strollers, car seats, crutches, etc. and weights of devices.)

Companion 1: Name ____ DOB:______________ Wt:___________
Relationship: __________________ Cell: ____________________
Email:_____________________________________
Companion 2: Name ____ DOB:______________ Wt:___________
Relationship: __________________ Cell: ____________________
Email:_____________________________________

Emergency contact (not traveling along):______________________________________ Cell:____________________
Relationship: _____________________________ Tel: ____________________

Releasing Agency/Hospital Name:_____________________________________ Tel:___________________
Releasing Physician: _____________________________________ Tel:__________________

Fax:___________________
Treatment Facility/Hospital Name: ____ Tel:
____
Treating Physician: ____ Tel:__________________
Fax:_________________
Lodging Name: ____ Tel:
____
Ground Transportation:
____
Passenger and any companions have watched the video about flying in a small airplane; Please initial
_________ ____
Medical Insurance Carrier: Private____ Medicare____ Medicaid____ None____
Combined Household Income: __________________ This information is being requested for statistical purposes and your specific information will not be disclosed to any party without your consent.
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Additional comments: