Ministry of Health
Sultanate of Oman

CAA
هيئة الطيران المدني

Patient's Medical Evaluation form

Date of issuing the Form: _____ (Must not excessed 48H from Discharge Date)
Date of discharge from Hospital: _____ (Must not excessed 96H from the date of Departure to Oman)

1. Passenger details:

Passenger full name: _____
Age: _____ Gender: _____ Civil Number: _____ Mobile Number: _____
Home address in Oman: _____

2. Treating hospital:

Hospital Name: _____
Country: _____ Province: _____
Address and contact number: _____
Date of admission (if applicable): _____ Date of discharge (if applicable): _____
(Please attached a copy of the Discharge Summary report of the patient)

3. Patient Status:

Patient is fit to take care of him/her self: □Yes □ No (If No State the reason below and fill the an accompanying Person)

State the reason

Patient needs an accompanying Person (s): {for Male patient (1) and Female/child (2) as per MoH-Oman}

1st Accompanying person[1]:	2nd Accompanying person:
i. Name:_____	i. Name:_____
ii. Civil Number: _____	ii. Civil Number: _____
iii. Mobile number: _____	iii. Mobile number: _____
iv. Home address: _____	iv. Home address: _____

I Dr. _____ hereby declare that the information above is true, complete and correct to the best of my knowledge and belief. I understand that in the event of my information being found false or incorrect at any stage, a legal action will be taken against me and my employing institution.

Dr. Name: *Hospital Stamp*
Signature and stamp:

[1] The accompanying person is the person whom is eligible for exemption by proxy.