TEMPORARY EXEMPTION REQUEST DUE TO MEDICAL INABILITY TO BE COVID-19 VACCINATED

This form is interactive. You can type your information into the form and then print before you sign. If you fill in by hand, be sure to print legibly; this will help avoid processing delays.

Fees for completion of this form are the responsibility of the patient.
Please fill in completely; accommodation decisions will not be made with incomplete forms. Submit completed forms to Swoop by e-mail to medical@flyswoop.com or by fax to 1-844-212-5513

Requests for vaccine exemption will only be considered upon completion and presentation of this form a minimum of 14 days in advance of scheduled flight of departure for domestic flights within Canada and for outbound flights from Canada only. Incomplete forms and unsigned forms will not be considered.

PATIENT INFORMATION

Last name *(provide name exactly as shown on travel identification)*

First name

Middle name

Birthdate MM/DD/YYYY

E-mail

Contact number

Address

Town/City

Province/State

Postal code/ZIP

Country

Intended date of travel MM/DD/YYYY

Flight origin

Flight destination

Patient name

ALTERNATE CONTACT

Please provide an alternate contact (can be parent, guardian or decision maker) if patient is a child or cannot advocate for themselves. The alternate contact will have access to this medical information, may speak on patient's behalf for follow up questions and may be provided details regarding patient's onboard accommodation.

Name

Relationship

E-mail *(if different than patient's)*

Contact number *(if different than patient's)*

PATIENT CONSENT AND AGREEMENT

I consent and authorize my treating medical professionals to provide and discuss the information on this form, other medical information or my previous travel history with Swoop as required to facilitate my safe air travel. This consent and authorization extends to any medical professional holding information relevant to my assessment by Swoop, or any support organization arranging travel on my behalf. I consent to the collection and retention of the medical information on this form for the purposes of facilitating travel, with the understanding that this medical information will be kept confidential in accordance with Swoop's Privacy Policy.

I understand that if approved, Swoop will exempt me from the Government of Canada's requirement to be fully vaccinated against COVID-19 in order to board an aircraft, with respect to all Swoop-operated flights for my specified approval period. I understand that I will still be required to adhere to all other airport and airline safety policies and requirements. I agree to abide by the terms of my COVID-19 vaccine exemption as outlined by Swoop and the Government of Canada. I acknowledge that Swoop reserves the right to update the terms of my COVID-19 vaccine exemption at any time based on Government of Canada direction and/or Swoop policies. I acknowledge that I am responsible for providing updated medical information if any significant change(s) to my health relating to my exemption occurs, and I agree to provide such information to Swoop immediately.

Signature *(patient/guardian/or decision maker)*

Date MM/DD/YYYY

Patient name

PHYSICIAN OR NURSE PRACTIONER DETAILS

All remaining must be completed by a **medical physician or Nurse Practitioner** practicing in Canada.

You must select the appropriate rational box and provide the requested information in the free text area. If your patient's medical rationale for a COVID-19 vaccination is not listed, then they **will not be approved** to fly with WestJet without being vaccinated for COVID-19. The federal mandate only accepts COVID-19 vaccine exemptions supported by the National Advisory Committee of Immunization (NACI) and Swoop is fully supporting this mandate with no exceptions. Submission of additional objective medical information may be provided to support medical exemption request.

Physician name

License number

Province/Country of registration

Town/City

E-mail *(optional)*

Contact number

Fax

Date of first visit MM/DD/YYYY

Is the patient regularly in your care? ◯ No ◯ Yes

Physician initials

Date

Patient name

Part A: Objective Medical Information

To be completed by physician or nurse practitioner.

I, _____, hereby confirm that the person to be exempted above is unable to be vaccinated due to one of the following reasons:

1. Certified medical contraindictions to full vaccination against COVID-19 with an mRNA vaccine, as based on the recommendation of the National Advisory Committee on Immunization (NACI). The following are certified medical contraindiction as of October 22, 2021:

   ☐ A confirmed history of anaphylaxis following administration of a mRNA COVID-19 vaccine substantiated by objective documentation from a physician or nurse practitioner, or report from an emergency room/medical visit following previous administration of a mRNA COVID-19 vaccine. Per NACI guidelines most people who experience a severe immediate allergic reaction after their initial dose of an mRNA COVID-19 vaccine can experience safe subsequent doses of the COVID-19 vaccine after consultation and/or management by an allergist or appropriate physician.

   Please indicate date allergy was confirmed and by whom along with credentials.

   Name and credentials

   Date of mRNA COVID-19 vaccine administration MM/DD/YYYY

   Date of emergency room/medical visit MM/DD/YYYY

   ☐ A confirmed severe/anaphylactic allergy to polyethylene glycol (PEG) found in Pfizer-BioNTech and Moderna COVID-19 vaccines as confirmed by an allergist. (Note that if a person is allergic to tromethamine which is found in Moderna, they can receive the Pfizer-BioNTech product).

   Please indicate date allergy was confirmed and by whom along with credentials or date of emergency room/medical visit following previous administration of PEG product.

   Name and credentials

   Date allergy was confirmed or date of emergency room/medical visit MM/DD/YYYY

Patient name

2. Medical reasons for delay of full vaccination against COVID-19 as described by NACI. As of October 22, 2021, this may include:

   ☐ A history of myocarditis/pericarditis following the first dose of an mRNA vaccine where emergency department visit or hospital admission warranted treatment and/or follow up by cardiologist.

   Please indicate the date of cardiac consultation or cardiac workup where the abnormal result was noted. Per NACI guidelines, if there has been no cardiac workup or if there are normal cardiac investigations, the next dose of the COVID-19 vaccine can be administered once the patient is symptom-free and 90 days have passed since the first vaccination. If a cardiologist referral has been made, indicate the date of referral or confirmed appointment.

   Name and credentials

   Date of referral or confirmed appointment MM/DD/YYYY

   Is your patient currently symptomatic? ○ No ○ Yes

   If cardiac referral has been completed, then please indicate the date of referral and outline the recommendation.

   Recommendation

   Date of cardiologist visit MM/DD/YYYY

3. An immunocompromising condition in and of itself may be insufficient for a vaccine exemption approval. Per NACI guidelines, immunocompromising conditions/medications may be approved for a temporary deferral of vaccination so that an immune response can be maximized. Please indicate the immunocompromising condition and date of onset/ exacerbation. For immunosuppressant medication, indicate the date of administration.

   ☐ **Immunocompromising condition, date of onset and exacerbation:**

   The anticipated date for COVID-19 vaccination administration: MM/DD/YYYY

   ☐ **Name of medication that results in a temporary delay of the Covid-19 Vaccination and date of administration:**

   The anticipated date for COVID-19 vaccination administration: MM/DD/YYYY

Prognosis for a safe flight with no extraordinary medical attention

○ Good ○ Poor if the patient has any of the following:

a) An unstable medical condition
b) A medical condition that may worsen at altitude in a hypoxic environment
c) May require medical assistance or emergency medical equipment during flight

Is your patient fit to fly? ○ No ○ Yes

Physician initials

Date

Patient name

Communicable disease

Does the patient have an active communicable infection/disease that can be transmitted or pose a direct threat to the health and safety of other individuals during the normal course of their travel?

- ○ Not applicable (skip)
- ○ Yes - Please complete the following

Condition type/explain

Are there any precautions needed to prevent the spread of infection or disease during the course of their travel?

- ○ No
- ○ Yes

Explain

Part B: Attestation

Physician or Nurse Practitioner name *(please print)*

I am a

- ○ Physician (M.D.) licensed to practice medicine in a jurisdiction of Canada
- ○ Nurse Practitioner licensed in a jurisdiction in Canada

By signing below, I affirm that I have reviewed the current NACI contraindications to Covid-19 Vaccination and affirm that the stated contraindication(s) is consistent with established national standards for vaccination practices. I acknowledge that Westjet reserves the right to request additional objective verifying information to substantiate a COVID-19 vaccine exemption claim. As per the applicable Interim Order Respecting Certain Requirements for Civil Aviation Due to COVID-19, a person who provides information to a carrier that is known to be false or misleading may also be subject to an administrative monetary penalty or other enforcement action, including prosecution.

Signature *(Physician/Practitioner)*

Date MM/DD/YYYY

Physician office stamp required

Physician initials

Date