



Pilots for Christ, Incorporated

Post Office Box 707 Monroeville, Alabama 36461 -- Phone 251-575-3200 or 251-575-9425

FAX 251-575-3106 or 251-575-7746 -- E-mail address: pilotsforchrist@yahoo.com

"Whatever you did for one of the least of these brothers of mine, you did for me." ~ Matthew 25:40

MISSION SETUP

Mission Date _____ Mission # _____ Medical Condition _____

Patient _____ Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

MISSION DETAILS:

	<u>FROM</u>	<u>ETD</u> (local)	<u>TO</u>	<u>ETA</u> (local)	<u>PILOT INFORMATION & A/C</u>
Leg 1					Name
Airport Name					Day Phone
City/State					Night Phone
FBO			FBO		Cell Phone
Phone			Phone		Type /Tail #

	<u>FROM</u>	<u>ETD</u> (local)	<u>TO</u>	<u>ETA</u> (local)	<u>PILOT INFORMATION & A/C</u>
Leg 2					Name
Airport Name					Day Phone
City/State					Night Phone
FBO			FBO		Cell Phone
Phone			Phone		Type /Tail #

<u>Name(s)</u>	<u>Weight</u>	<u>Age/DOB</u>	<u>Relation to Patient</u>	<u>Notes</u>
Patient/Pass.				Assisting agency notified:
Patient/Pass.				Who
Patient/Pass.				Date
Patient/Pass.				Final notification date
Patient/Pass.				Pilot
Med. Equip.				Patient
Baggage				Connecting Agency
<u>TOTAL WEIGHT</u>				Phone

-- Before Departure --

1. Obtain a weather briefing, perform a Weight and Balance, and file Flight Plan.
2. Use "Lifeguard" in call sign only when conditions warrant.



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CHECKLIST FOR PFC AIR TRANSPORTATION SERVICES

Church and Pastor's Name: _____

Phone Number (Day) _____ (Night) _____

Patient's Name: _____ Date of Birth _____

Patient's Phone Number: (Day) _____ (Night): _____

Patient's Cell Number: _____ e-mail: _____

Patient's Medical Condition: _____

Nature of Need: _____

- (a) Time-Critical (b) Financially Needy [individual and family unable to provide finances for trip]
- (c) Compassion [physically unable to travel by any other means] (d) Lack of local/nearby commercial service
- (e) Low Immunity System (f) Other, please explain _____

Travel Information:

Requested Date of Travel: _____

Preferred Departure City: _____

Preferred Destination City: _____

Contact Name and Number at Destination City: _____

How many Passengers? (No guarantee of seats for more than 2.) _____

Will a return flight be necessary? No Yes If yes, what date? _____/_____/_____

Other important information:

1. **In an effort to be good stewards of the resources God provides Pilots for Christ, we seek to focus our services on individuals and families during their critical time of need. Normally, it has been our experience that the early stages of treatments for various medical conditions are quite simply regular doctor's visits, entail no medical procedures are not in need of our services. Likewise, after successful medical procedures and/or operations, there are many visits to have a short medical checkup. Our ministry is to be available to those in times of need. In order to do this, we must limit our services to be available during the time when actual medical procedures/treatments are being administered.**
2. Patients must understand that while they may carry their own oxygen in an FAA-approved container, PFC volunteers are not able to provide any medical service before, during, or after the flight.
3. Patients must be aware that we do not arrange ground transportation.
4. Passengers should be aware that baggage in excess of 40 pounds per person total may not be accommodated.
5. Patients should have back-up transportation in the event of a last minute cancellation of our flight, such as inclement weather
6. Patients must be physically fit to travel in a non-pressurized aircraft up to 11,000 feet MSL, without access to lavatory facilities, for the duration of the flight.
7. A letter from a doctor indicating that the person can travel, and any special equipment that may be needed. We will not accept flight if the person requires any special equipment. Example: Life support equipment, incubator, etc. Wheel chair may be accepted.
8. Is the destination city served by a commercial airline? This will us help determine the cost effectiveness of this trip.
9. Trip leg length not more than 350 nautical miles. May be longer at discretion of President and pilot in command.
10. Time-critical flights will be evaluated on a per case basis.
11. Is the person able to get into and out of the aircraft without help, or with minimal help?
12. The person must require no enroute medical care or assistance.
13. We appreciate your understanding of our guidelines in order that we may more effectively serve those in need.



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CHECKLIST FOR PCI AIR TRANSPORTATION SERVICES

Name (Please Print): _____

Date of Birth: _____ Sex: Male Female Weight: _____ Lbs.

Physician's Name: _____ Phone: _____

Does your Physician know you making this flight? Yes No

Why are you requesting to be transported by aircraft? _____

When was the last time you have flown? (Date) ____/____/____ Did you experience any chest pain, shortness of breath, or any other problems? Yes No If yes, please explain: _____

Do you have any history of:

• **Cardiovascular problems?**

High Blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aneurysm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina or chest pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive heart failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other?	_____	

• **Respiratory problems?**

Shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pleurisy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lung cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lung abscess?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other?	_____	

• **Blood disease or clotting problems?**

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anticoagulant therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leukemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sickle cell anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other?	_____	

• Are you using any supplemental oxygen at home? Yes No
How long at a time? _____ How often? _____

- Do you currently have a "head cold?" Yes No
- Have you had any dental work done within the past 48 hours? Yes No
- Are you pregnant? Yes No If yes, how many weeks? _____
- List any medications that you are taking: _____



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MEDICAL SCREENING PROCEDURE CHECKLIST

Name (Please Print): _____

1. The following documents have been completed and/or received:

- Letter from Physician on his/her letterhead. Yes No
- Medical Screening Questionnaire. Yes No

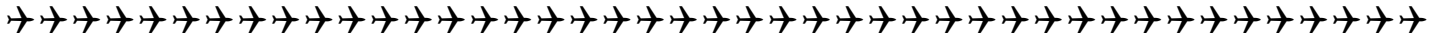
2. Following review of the Medical Screening Questionnaire, the Physician’s letter and the acceptance criteria under Persons Eligible for Humanitarian Flights to include Ministers and Mercy Flights, it has been determined that:

_____ The individual meets the criteria for transport.

_____ The information regarding the individual will require follow-up with the individual’s Physician prior to acceptance for transport.

Signature: _____ Date: _____

Title: _____



Follow-up and Determination

I have reviewed the information on the individual’s Medical Screening Questionnaire by phone with individual’s Physician who: Has forwarded Will be forwarding a written approval for the flight. After my discussion with the Physician, he/she supports the decision to Allow Not allow transport in a light aircraft.

Summary of discussion with the Physician, and conclusions:

_____ The individual meets criteria for transport.

_____ The individual does not meet the criteria for transport, and will be referred to a more appropriate health care/air ambulance.

Signature: _____ Date: _____

Title: _____



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FAX TRANSMITTAL COVER SHEET

Date: _____

Time: _____

Please deliver the following pages to:

Name: _____

FAX Number: _____

From: Pilots for Christ, Incorporated

Our Rep.: _____

Total pages including cover sheet _____

If this message is not received clearly, please inform us by phone at 251-575-3200 or 251-575-9425.

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Date

Name

Address

City, State, Zip

Dear Doctor,

Your patient has requested assistance from Pilots for Christ, Incorporated for air transportation to obtain medical treatment, which is not available locally. In order for us to accommodate this request, we need a physician's evaluation of the patient's ability to make a flight in a light aircraft.

The following is pertinent information concerning the patient, and the proposed flight:

Patient's Name: _____

Date tentatively scheduled for the flight: _____

Flight is from _____ **to** _____

Estimated flying time: _____ **hour(s); Layover time** _____ **hour(s)**

The patient would most likely be transported in a light General Aviation aircraft, unpressurized, and at altitudes of up to 11,000 feet above sea level, with no medical assistance provided enroute.

If you can approve this patient taking this flight, please do so on the following form and Fax it to our office as soon as possible at 251-575-3106 or 251-575-9425. If you have any questions, please do not hesitate to call.

Thank you for your help.

Sincerely,

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Physician's Evaluation of Eligibility

Patient's Name: _____ DOB: _____ Weight _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ -- _____

If patient is a minor, enter name of the parent or guardian: _____

Parent/guardian address if different from minor's _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ -- _____

Patient's Diagnosis: _____

Medical reason for requested travel: (Please circle all that apply.)

(a) Time-Critical

(b) Financially Needy [individual and family unable to provide finances for trip]

(c) Compassion [physically unable to travel by any other means]

(d) Lack of local/nearby commercial service

(e) Low Immunity System

(f) Other, please explain: _____

PILOTS FOR CHRIST, INC. IS NOT AN AIR AMBULANCE!

To the best of my knowledge, this patient/family is eligible for charitable transportation.

I am sufficiently familiar with aviation physiology to be of the opinion that this patient can travel in small aircraft at ambient pressure altitudes up to 11,000 feet above sea level, and that said patient has no need of medical assistance enroute.

Signed: _____, M.D./D.O. Date: _____



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Pilots for Christ, Incorporated Photo Release Form

_____ gives permission to Pilots for Christ, Incorporated
(Signature of Patient or Patient's Guardian)

South Alabama Chapter, to use any photograph(s) taken before, during, or after this mission flight for publicity purposes associated with the promotion of Pilots for Christ via news releases and/or other printed materials and does also relinquish any rights of ownership to said photograph(s).

Date

Pilots for Christ Representative

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Pilots for Christ, Inc. (PFC), a non-profit, volunteer public service organization and its volunteer pilot(s) hereby agree to provide the following passenger(s)

_____ (and) _____
with air transportation, free of charge, for the passenger's convenience in obtaining, assisting with, or returning from medical treatment or diagnosis, or any other PFC approved mission flights.

In consideration for receiving this air transportation free of charge, I agree to hold harmless PFC and its volunteer pilot(s) from any and all liability, including, but not limited to, liability for negligence, for any personal injury or property damage I might suffer, and for any wrongful death action which my estate might otherwise bring arising out of such injury, while I am a passenger on the aircraft arranged by PFC and flown by its volunteer pilot(s). I further declare that I do not need any medical assistance during this flight, and I understand this flight will be conducted under Part 91 of the Federal Aviation Regulations which does not require the same standards that apply to a commercial flight. (Part 121 or 135.)

I understand it is my sole and exclusive responsibility to purchase any flight or accident insurance should I desire to be insured on this flight. I also understand PFC is not responsible for a pilot's currency requirements, however, I may contact the pilot prior to flight for verification.

In the event that any portion of this agreement is held invalid, the remaining portions shall remain in full force and effect.

I understand that in order to continue to provide its free community service PFC relies upon contributions which are in part solicited through publicity. In order to contribute to their efforts, I grant PFC permission to take and use my photograph and personal information and medical information for prayer, promotion and public relations.

As evidenced by my signature below, I have read this agreement in its entirety and agree to its terms.

Print Name (Passenger 1)

Print Name (Passenger 2)

Signature

Signature

Date Signed

Date Signed

Street Address

Street Address

City, State, Zip

City, State, Zip

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Mission # _____	Report
Date: _____ IFR Fuel Req'd. _____	Fuel On Board _____
Pilot: _____	NM _____
Co-Pilot: _____	HOBBS HRS. _____
Names of Persons on Board:	Incidental Expenses:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
Prayer: _____	Additional Comments:
Time of Startup: _____	_____
Time of Shutdown: _____	_____
Departure Point: _____	_____
Destination: _____	_____
Type Plane: _____	_____
N-Number: _____	_____
OAT at Cruise: _____	_____
FL or Altitude: _____	_____
IAS: _____	
TAS: _____	
GPH or PPH IN CRUISE: _____	
VFR/IFR: _____	
Day/Night: _____	
CG T/O: _____ LDG: _____	

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MISSION ACKNOWLEDGEMENT

To: _____

Please accept our sincere thanks for your generous in-kind donation to the purposes and functions of our organization. Your contribution is described as follows:

Date of Mission: _____ Mission Number: _____

Passengers: _____

Purpose of Flight: _____

Route of Flight: _____

Certified by: _____

**Tommy Lee, President
Pilots for Christ, Incorporated**

To Calculate the Value of Your Contribution:

Aircraft Used:....._____

A. Hours Flown:_____ Hrs.

B. If owned, Hourly Operation Cost\$_____

If rented, Hourly Rental Cost:\$_____

C. Total Operating Cost: (A times B)\$_____

D. Incidental Expenses: (attach your receipts)\$_____

TOTAL VALUE OF CONTRIBUTION (C plus D).....\$_____

Important Note: There is no credit for pilot services or personal time. All flights are flown on a voluntary basis and under FAR Part 91. You are responsible for the accuracy of the above information. It is suggested that you save all pertinent records and this form for your personal records. Pilots for Christ certifies only the mission and its parameters.

Thank you for your contribution!