

HEALTH FORM

Name : Surname :

Date of birth:

BLOOD GROUP

Please answer only if you are certain of your blood group.

A+ A- O+ O- B+ B- AB+ AB-

HEALTH PROBLEMS

As a preventive measure, please inform us if you have or have had any medical issue

- Do you require a special diet (any allergy, intolerance) ?

Remarks :

- Other health problems ?

Remarks :

INSURANCE

Name of your accident insurance :

Address : Tel :

Name of your repatriation insurance :

Address :Tel :

CONTACT PERSON

Your contact in case of emergency

Name : Surname :

Address : Tel. :

Remarks :

TURKEY HELISKI

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In case of emergency I authorize Turkey Heliski SA to take the decisions and measures it deems necessary, including the choice of hospital and repatriation.

DATE: SIGNATURE: