AIR CANADA | In-Flight Service
Crew Scheduling & Planning

Received: _____

Special Meal Validation Form - Medical

In order for Air Canada to meet its legal duty to accommodate persons requiring special meals for medical reasons, we require the following form to be completed by your treating physician and returned to your local base Manager.

EMPLOYEE INFORMATION:

Name:		**Crew Code**	
Base:			

To be completed by TREATING PHYSICIAN

☐ **Lifestyle Choice –** There is not an underlying diagnosed medical impairment. Employee requests a special meal type as part of his/her dietary choices.

☐ **Medical / Therapeutic Requirement –** There is a medical / therapeutic requirement for a specific meal type related to a diagnosed medical impairment****** (such as a diabetic meal for an employee with diabetes, a gluten intolerant meal for an employee with Celiac Disease or a low cholesterol meal for someone with hyperlipidemia).

NOTE: We ask that you not disclose private, confidential medical information (i.e. diagnosis, results of diagnostic tests and/or treatment(s)) on this form. If a follow-up is required by Air Canada's Occupational Health Services, additional relevant information may subsequently be requested by the employee.

The list below fits within an "evidence-based" dietary guideline (e.g. Canadian Diabetes Association Clinical Practice Guidelines). Please select the meal **(1)** that the employee has been advised to follow as part of their treatment plan:

☐ Strict Vegetarian Meal	☐ Vegetarian Lacto-Ovo Meal
☐ Asian Vegetarian	☐ Low Calorie Meal
☐ Low Salt Meal	☐ Low Fat/Cholesterol Meal
☐ Low Lactose Meal	☐ Diabetic Meal
☐ Gluten Intolerant Meal	☐ Bland/Ulcer Meal
☐ Fruit Plate	☐ Other

If selecting "Other", please specify / describe requirement(s) below (attach additional sheets if needed).

_____

_____

****** *Air Canada reserves the right to request verification of the recognized diagnosis at a later date, along with copies of objective medical data (e.g. results of blood tests), to substantiate the therapeutic or medical requirement for a specific meal type related to a medical impairment*.

How long will the dietary requirement be in effect and/or special meal be required?

_____

Treating Physician Signature: _____

Treating Physician Name *(please print)*: _ _____

Treating Physician Telephone Number: __ _____

STAMP