



Fuel Reimbursement Program

Pilot Opt-In

Pilot Identification			
LAST NAME	FIRST NAME	MIDDLE NAME	CODE
STREET ADDRESS			
CITY		STATE	ZIP CODE
DAY TELEPHONE	CELL TELEPHONE	TRANSPLANT PILOTS ONLY - NIGHT TELEPHONE	
EMAIL			

Self-Certification	
<p><i>The Fuel Reimbursement Program requires you to agree and conform to each of the requirements listed below. Initial each line to signify you will comply.</i></p>	
	I have read Federal Aviation Administration (FAA) Exemption No. 10513A dated January 30, 2013, and will adhere to all the requirements of the exemption.
	I understand that this is a voluntary program and wish to participate.
	I have an Instrument Flight Rules (IFR) rating.
	I have at least 500 hours as Pilot in Command (PIC).
	I will apply for reimbursement of fuel cost only for flight legs that are directly in support of patient transport and meet all requirements of the exemption. (Legs of small deviation for refueling are permitted).
	I agree to abide by the Initial and Recurrent Training Requirements.
	I agree to obtain and maintain a 2nd Class Medical prior to and during participation in the program.
SIGNATURE	
DATE	