

UPDATED PHYSICIAN'S STATEMENT

Delta Pilots
Disability and
Survivorship Plan

Return Completed form to:

Harvey W. Watt & Co.
P. O. Box 20787
Atlanta, GA 30320
FAX (404)761-8326

The patient is ultimately responsible for the completion of the entire form and facilitating the submission of necessary documentation without any expense to either Delta Pilots Disability and Survivorship Plan or Harvey Watt & Co. Necessary documentation includes but is not limited to: office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc.

A separate form must be completed by each treating physician.

If a section is not applicable, N/A MUST be entered. Any incomplete form may be returned for completion.

TO BE COMPLETED BY PATIENT:

Patient: _____
Address: _____

Phone Number: _____
Height of Patient: _____ Weight of Patient: _____
Date of Birth: _____

Doctor: _____
Address: _____

Phone Number: _____
Fax Number: _____
Specialty: _____

TO BE COMPLETED BY PHYSICIAN:

DIAGNOSIS:

Primary Diagnosis: _____
Primary Diagnosis ICD-9 Code: _____
Primary Diagnosis PCT-4 Code (if applicable): _____

Secondary Diagnosis: _____
Secondary Diagnosis ICD-9 Code: _____
Secondary Diagnosis PCT-4 Code (if applicable): _____

DATE OF LAST MEDICAL UPDATE SUBMITTED TO HARVEY WATT: _____

LIST ALL DATES OF SERVICE SINCE _____:

Detailed description/history ***INCLUDING*** the office notes and summaries of all surgical or medical services rendered on each date, including laboratory test results and results/reports of any other tests, such as X-RAYS, EKG's, EEG'S, etc. (Please attach additional pages if more space is needed.):

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Recommended/Prescribed treatment, including any therapy or medications. (Please attach additional pages if more space is needed.):

Detail all of the patient's restrictions and activity limitations. (Please attach additional pages if more space is needed.):

Current Physical/Functional Level of Patient:

- Sedentary 0 to 10 lbs lifting; limited standing or walking
- Light 11 to 20 lbs lifting; carry objects less than 10lbs for short periods
- Medium 21 to 50 lbs lifting; carry objects 25lbs for short periods
- Heavy 51 to 100lbs lifting; carry objects up to 50lbs

These restrictions are in effect until _____(date) or until Plan Participant is reevaluated on _____(date).

Since first being consulted on the patient's disability, please describe his/her condition

- () Regressed () Unimproved () Improved () Recovered
-

Do you believe the patient is now able to perform the duties of his/her customary occupation as airline pilot? () Yes () No

Do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate? () Yes () No

List dates of total and continuous disablement preventing engagement in his/her customary occupation:

Date patient was able to return to his/her customary occupation: _____

Estimated date patient will be able to return to his/her customary occupation: _____

NOTE: If duration of disability exceeds a 90-day period, all medical documentation will be required for each subsequent 90-day period.

Physician completing form:

Printed Name: _____

Signature: _____

Date: _____