NETJETS®

INITIAL PHYSICIAN'S STATEMENT

NetJets Aviation, Inc.
SALCO and LOM
Disability Plans
800-241-6103

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 submitting the completed forms and necessary documentation without any expense to either the NJA SALCO or LOM Disability Plans or to Harvey Watt & Company. 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 <u>PHYSICIAN</u>:

DIAGNOSIS:

Primary Diagnosis:

Primary ICD-9/10 Code:

Primary CPT-4 Code (if applicable):

Date Patient first consulted for this disability:

Secondary Diagnosis:

Secondary ICD-9/10 Code:

Secondary CPT-4 Code (if applicable):

Date symptoms first appeared for this disability:

LIST <u>ALL</u> DATES OF SERVICE:

DATE OF NEXT SCHEDULED VISIT:_____/_____/_____

LIST <u>ALL</u> LOCATIONS OF SERVICE:

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INITIAL PHYSICIAN STATEMENT (Page 2)

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.):

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

List all medications including name, dose, frequency and start date:

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 up to 25lbs for short periods
☐	Heavy	51 to 100 lbs lifting; carry objects up to 50lbs

These restrictions are in effect until_____(date) or until Plan Participant is reevaluated on_____(date).

Detail all dates of hospital confinement that pertain to the listed disability. (Include admittance and discharge dates as well as the reason for the confinement.):

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INITIAL PHYSICIAN STATEMENT (Page 3)

List the names and address of ALL consulting physicians for the listed disability:

Detailed Prognosis for Return to Work:

Since first being consulted on the patient's disability, please describe their condition:

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

Do you believe the patient is now able to perform the duties of his/her customary occupation as a NetJets 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

Date patient was able to return to his/her customary occupation as a NetJets pilot:

_____

Estimated date patient will be able to return to his/her customary occupation as a NetJets pilot:

_____

NOTE: If duration of disability exceeds a 14-day period for SALCO or 90-day period for LOM, all medical documentation may be requested for each subsequent 14-day or 90-day period.

Physician completing form:

Printed Name:

_____

Signature: Date:

_____ _____

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UPDATED PHYSICIAN'S STATEMENT

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Disability Plans
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Return Completed form to:

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P. O. Box 20787
Atlanta, GA 30320
FAX (404)761-8326

The patient is ultimately responsible for submitting the completed forms and necessary documentation without any expense to either the NJA SALCO or LOM Disability Plans or to Harvey Watt & Company. 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 <u>PHYSICIAN</u>:

DIAGNOSIS:

Primary Diagnosis: _____

Primary Diagnosis ICD-9/10 Code: _____

Primary Diagnosis CPT-4 Code (if applicable): _____

Secondary Diagnosis: _____

Secondary Diagnosis ICD-9/10 Code: _____

Secondary Diagnosis CPT-4 Code (if applicable): _____

DATE OF LAST MEDICAL UPDATE SUBMITTED TO HARVEY WATT: _____

LIST <u>ALL</u> DATES OF SERVICE SINCE _____:

Detailed description/history ***<u>INCLUDING</u>*** 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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UPDATED PHYSICIAN'S STATEMENT (Page 2)

Recommended/Prescribed treatment, including any therapy or medications. (Please attach additional pages, if 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 up to 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 a NetJets 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:

Actual date (if known) 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 14-day period for SALCO or 90-day period for LOM, all medical documentation will be required for each subsequent 90-day period.

Physician completing form:

Printed Name:

_____

Signature:

_____ Date: _____

Return to Work Certification

Health Care Provider: Please complete this form using extra sheets if needed and return to employee.

Employee: deliver completed form to Comp & Benefits as soon as possible via fax to **(404) 761-8326** or email njapilot@harveywatt.com and keep a copy for your records. Failure to return this form in a timely manner will result in a delay to your return to work and your next scheduled paycheck.

Employee Name (Print) _____

☐ **The above employee may return to work with no restrictions on_____.**

☐ **The above employee may return to work with restrictions from_____to_____.**
*** Please complete the work capabilities below:*

% of Workday or Repetitions/Hour	Not at all	Occasionally 1-33% 4-6 times/hour	Frequently 34-66% 6-12 times/hour	Continuously 67-100% >12 times/hour
Lift/Carry				
Up to 10 lbs				
11-29 lbs				
30+ lbs				
Bend				
Twist/Turn				
Reach below knee				
Lift above shoulders				
Push/Pull				
Squat/Kneel				
Stand				
Walk				
Sit				
Repetitive activities				

☐ **No lifting greater than_____lbs.** **No use of ☐ Left ☐ Right ☐ Both**
☐ Hand(s) ☐ Arm(s) ☐Leg(s) ☐Other_____.

☐ **Change positions every_____.** ☐ **Avoid driving/operating heavy machinery These**

restrictions are ☐ permanent ☐ temporary. Duration if temporary:_____.

☐ **Follow-up appointment scheduled for_____.**

Health Care Provider Printed Name _____

Health Care Provider Signature_____Date _____

Address_____Phone _____

Employee Signature_____ Date _____

If required:
HR/Labor Relations Signature_____Date _____