INITIAL PHYSICIAN'S STATEMENT

Delta Pilots
Disability and
Survivorship Plan (D&S 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 ICD-9 Code:

Primary PCT-4 Code (if applicable):

Date Patient first consulted for this disability:

Secondary Diagnosis:

Secondary ICD-9 Code:

Secondary PCT-4 Code (if applicable):

Date symptoms first appeared for this disability:

LIST ALL DATES OF SERVICE:

LIST ALL LOCATIONS OF SERVICE:

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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 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).

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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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

If you are an Aviation Medical Examiner (AME), do you believe the patient is now able to exercise the privileges of a Federal Aviation Administration First Class Medical Certificate? ( ) Yes ( ) No ( ) N/A

Date patient was able to return to customary occupation as an airline pilot:

_____

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

Physician completing form:

Printed Name:

_____

Signature: Date:

_____ _____