INITIAL PHYSICIAN'S STATEMENT

Southwest Airlines Co.
Loss of License Plan

Return Completed form to:

Harvey W. Watt & Co.
P. O. Box 82876
Atlanta, GA 30354
PH. (800) 241-6103
FAX (404) 761-8326
Southwest@harveywatt.com

In order to assist us in expediting the processing of the disability claim for the employee we require you to complete this form in full and enclose the necessary documentation and return it to us. **The patient is responsible for the completion of the form and the attachment of the necessary documentation without any expense to either Southwest Airlines Co., or Harvey W. Watt & Co. Inc.**

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:

Are you receiving, eligible to receive of have you applied to receive benefits from:

	Eligibility	Applied for Benefits	Application Date	Receiving	Date First Received
Social Security	**( ) Yes ( ) No**	**( ) Yes ( ) No**		**( ) Yes ( ) No**	
Worker's Compensation	**( ) Yes ( ) No**	**( ) Yes ( ) No**		**( ) Yes ( ) No**	

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

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 their customary occupation as an airline pilot? ( ) Yes ( ) No

Dates of Total and Continuous Disablement Preventing engagement in their customary occupation:

Date patient was able to return to their customary occupation:

Estimated date patient will be able to return to their customary occupation:

Do you believe the patient is now able to perform the duties of any gainful occupation? ( ) Yes ( ) No

Dates of Total and Continuous Disablement Preventing engagement in any gainful occupation:

Date patient was able to return to any gainful customary occupation:

Estimated date patient will be able to return to any gainful customary occupation:

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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.):

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

Detailed Prognosis for Return to Work:

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:**