INITIAL PHYSICIAN'S STATEMENT

ExpressJet Airlines, Inc.
Long Term Disability
Program for Pilots

RETURN COMPLETED FORM TO:

Harvey Watt & Co.
P. O. Box 20787, ATL Airport
Atlanta, GA 30320
FAX-404-761-8326

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 enclosing the necessary documentation and returning it to us.
The patient is responsible for the completion of this form and the attachment of the necessary documentation without any expense to either Continental Airlines, Inc. or Harvey Watt & Co.

TO BE COMPLETED BY PATIENT:

Patient: ____

Address:
____
____
____
____

Phone Number: ____

Height of Patient: ________________ Weight of Patient: ____________________

Date of Birth: ____

Social Security Number: ____

Doctor: ____

Address:
____
____
____
____

Phone Number: ____

Fax Number: ____

Specialty: ____

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

	Eligibility	Applied for Benefits	Application Date	Receiving
Social Security	( ) Yes ( ) No	( ) Yes ( ) No		( ) Yes ( ) No
Worker's Compensation	( ) Yes ( ) No	( ) Yes ( ) No		( ) Yes ( ) No
State Disability	( ) Yes ( ) No	( ) Yes ( ) No		( ) Yes ( ) No
Retirement	( ) Yes ( ) No	( ) Yes ( ) No		( ) Yes ( ) No

If yes, please specify the source(s):____
____

Other:	( ) Yes ( ) No	( ) Yes ( ) No		( ) Yes ( ) No

If yes, please specify the source(s):____
____

TO BE COMPLETED BY PHYSICIAN:

DIAGNOSIS:

Primary: ____

Primary ICD-9 Code: ____

Primary PCT-4 Code (if applicable): ____

Date Patient first consulted for this disability: ____

Secondary: ____

Secondary ICD-9 Code: ____

Secondary PCT-4 Code (if applicable): ____

Date symptoms first appeared for this disability: ____

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

LIST <u>ALL</u> 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 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 patients restrictions and activity limitations (Please attach additional pages if more space is needed):

Since first being consulted on the patients disability please describe their condition

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

Do you believe the patient is now able to perform the duties of <u>their</u> <u>customary</u> occupation as airline pilot? ( ) Yes ( ) No

Dates of Total and Continuous Disablement Preventing engagement in <u>their</u> customary occupation:

Date patient was able to return to <u>their</u> customary occupation:

Estimated date patient will be able to return to <u>their</u> customary occupation:

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

Dates of Total and Continuous Disablement Preventing engagement in <u>any</u> <u>gainful</u> occupation:

Date patient was able to return to <u>any</u> <u>gainful</u> occupation:

Estimated date patient will be able to return to <u>any</u> <u>gainful</u> occupation:

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:

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Detailed Prognosis for Return to Work:

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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: ______________________________________

Type or Print