
Medical Verification Statement: Portable Oxygen Concentrators

This letter is my verification that _____ requires the use of
(Passengers Printed Name)

Supplementary oxygen while traveling and this requirement can be met through the use of an approved portable oxygen concentrator (POC).

I verify the following:

- That the passenger has the physical and cognitive ability to see, hear and understand **the POC's aural and visual cautions and warnings and is able, without assistance, to take the appropriate action in response to those cautions and warnings.**
- The use of the POC is medically necessary: (check requirement that best applies)
 - _____Continuously during all phases of the flight, including taxi, take-offs and landings.
 - _____Only during the portion of the flight when common electronic devices are authorized by the crew – generally after take-off and before landing.
 - _____Intermittently during flight, but not during taxi, take-off or landing.
- The oxygen flow rate setting for the POC is _____, considering the air pressure in the cabin under normal operating conditions.

I _____certify that the passenger named above is
(Doctors Printed Name)

under my care and in my opinion may travel on board a commercial aircraft without the likelihood of medical risk to their health and/or physical condition. My patient understands **that the POC is the patient's responsibility and the airline is not responsible for providing batteries, providing on-board power, providing nasal cannulas or other POC-related equipment, and that the airline is not responsible for the POC's physical condition. The patient is capable of completing the flight safely without extraordinary medical assistance and has been advised by me to have ample charged batteries to power the POC for the length of the flight plus three (3) additional hours to cover any unexpected delays, gate holds, diversions or cancellations.**

Any change to a patient's health that would amend the criteria listed above will require that an updated Physician's Medical Verification Statement be completed.

Physician Signature _____ DEA _____

Address _____

Office Phone Number _____ Date _____