Dear Physician,

Your patient desires to use a Portable Oxygen Concentrator on board a United aircraft for upcoming travel. In accordance with Federal Aviation Regulations, United requires a physician's verification of the customer's medical need to use this device while traveling on a commercial aircraft. Accordingly, please answer the questions below. After you have completed and signed this form, please return to your patient as this form must be in his or her possession and available for inspection on the day of travel.

We appreciate your time and assistance with this process.

United Airlines Medical Department

To be completed by the physician:

This letter is my verification that _____[printed passenger name] requires the use of supplementary oxygen while traveling and this requirement can be met through the use of an approved Portable Oxygen Concentrator (POC). I further verify the following:

- The passenger's use is medically necessary.
- 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 and any ground connection time where the POC will be used, plus three additional hours to cover any unexpected delays, gate holds, diversions or cancellations.
- Any change to the patient's health that would amend the criteria listed above will require that an updated Medical Certificate for POC Use be completed.

Please check the appropriate statement below:

- ◯ POC is medically necessary during all phases of the flight, including taxi, takeoff and landing.
- ◯ POC is medically necessary only during the portion of the flight when common electronic devices are authorized by crew, which is generally after takeoff and before landing.
- ◯ POC is medically necessary intermittently during flight, but not during taxi, takeoff or landing.
- ◯ The oxygen flow rate setting for the POC is _____ liters per minute (LPM), considering the air pressure in the cabin under normal operating conditions.

Physician contact information

PHYSICIAN'S NAME (PLEASE PRINT)	STATE LICENSE OR REGISTRATION NUMBER
TELEPHONE NUMBER	FAX NUMBER
ADDRESS	
CITY	STATE/COUNTRY
PHYSICIAN'S SIGNATURE	DATE