

Physician's Statement for Air Travel Portable Oxygen Concentrator

Pursuant to Federal Aviation Regulations, a traveler who would like to use a portable oxygen concentrator unit on board an airline must obtain a written statement from his or her physician answering the questions listed below.

This document is to remain in your personal possession and must be presented to airline representatives upon request. This document will not expire but must be available for every flight. Any changes in oxygen requirements such as revised flow rate will require an updated statement.

You are responsible for ensuring that your unit is in good condition and free from damage or excessive wear and tear. You are responsible for traveling with a sufficient supply of batteries to last the entire journey, per your oxygen requirements, including the duration of the flight, all ground time (before and after flight and during connections) and for unexpected delays. All batteries must be transported in carry-on (not checked) baggage and must be packed in a manner that protects them from damage or short circuits. Your portable oxygen concentrator, as well as the baggage containing the batteries should not count towards the carry-on limitation established by the airline, however, it would be beneficial for you to check with an airline representative prior to your arrival at the airport.

To be completed by physician:

Patient's Name: _____ Date: _____

Does the user of the device have the physical and cognitive ability to see, hear, understand, and take appropriate action in response to the device's aural and visual cautions and warnings? Yes No

Is oxygen use medically necessary for continuous use during taxi, take-off, landing and during flight?
 Yes No

Is oxygen use medically necessary for non-continuous use? Yes No

Explain: _____

Pressurized aircraft cabin altitude equals 8,000 feet above sea level. Recognizing the possible changes in cabin pressure during flight, the patient's required oxygen flow rate during flight is _____ LPM.

Physician's Name: _____

Physician's Address: _____

License Number / State: _____

Physician's Signature: _____

Date Signed: _____ Phone: _____