OSA STATUS REPORT - RECERTIFICATION

(Updated 02/23/2022)

Name _____ Birthdate _____

Applicant ID#_____ PI# _____

Please have your treating physician complete this report with the requested information. Submit either this summary or a clinic note from your physician detailing **ALL** the information below. **If treated with PAP device, include a copy of the most recent PAP download.** Submit all items to your AME or to the FAA:

Federal Aviation Administration
Civil Aerospace Medical Institute, Building 13
Aerospace Medical Certification Division, AAM-300, PO Box 25082
Oklahoma City, OK 73125-9867

1. Date of INITIAL or MOST RECENT sleep study..... / /

2. **Is the PRIMARY diagnosis Obstructive Sleep Apnea (OSA)?**..... Yes / No*
If NO, list diagnosis (central sleep apnea, restless legs syndrome, narcolepsy, insomnia, etc.)
_____

3. **Initial Apnea Hypopnea Index (AHI)**..... Initial AHI

4. Does the airman use any sleep or sedating medications?..... No / Yes*
(e.g. zolpidem, eszopiclone, trazodone, ropinirole, gabapentin, pramipexole, diphenhydramine.)
If YES, list medication name, dosage, frequency, and reason for use.*

5. If treatment **other** than PAP used, list type ⇨ then go to Question 11..... Type of treatment used

CURRENT PAP/CPAP/BIPAP/APAP COMPLIANCE REPORT DATA:

6. Date range of use..... From / To
Note: If TWO or more machines are used, download data should be supplied for EACH device. Annotate this information below. Questions 7-9 should reflect combined times. Certification decision is based on the cumulative use.

7. Device usage report: Based on the PAP device's current report, enter number of days the PAP device was actually used and the total number of days the PAP device report covers..... # of days actually used / # of days covered in report
Note: FAA medical certification is based on treatment for 365 days or 30 days for newly diagnosed/treated.
If less time represented, describe.*_____

8. Usage days - total percentage of days used..... Percentage days used
Note: **75% or more** is acceptable. If less than 75%, comment required.*

9. Usage hours - average usage (days used)..... Hours / Minutes
Note: **6 hours or more** is acceptable. If less than 6, comment required.*

10. Therapy - AHI..... AHI
Note: **5 or less** is acceptable. If 6 or higher, comment required.*

⇨ **11.** Is current treatment effective* with good control of symptoms, good compliance with therapy, and should be continued?..... Yes / No*
*Subjective screen (Epworth or similar), objective data (residual AHI and device leak, if applicable), and clinical exam reveal NO concern for residual daytime sleepiness.

12. *Explain any required responses and/or add any additional comments here:

_____ _____
Treating physician signature Date

Note: This OSA RECERTIFICATION Status Report is NOT required; however, it will help to significantly DECREASE FAA review time.

Pilots: When completed, send all items below as one package:

- A copy of this OSA Status Report - Recertification or a clinical note (with ALL required information) from your physician;
- A copy of the most recent sleep study, if not previously submitted; and
- Compliance data from PAP device representing 30 days if new diagnosis (may consider minimum of 2 weeks if data verifies excellent compliance, effective treatment, and resolved symptoms) OR 365 days if previously diagnosed and treated.