# DIABETES ON INSULIN Re-Certification STATUS REPORT

(Updated 07/31/17)

Name _____ Birthdate _____

Applicant ID# _____ PI# _____

Class Applied _____ Circle one: INITIAL / Re-Certification

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Please have the provider who treats your diabetes enter the information in the space below. Return the completed form to your AME or to the FAA at:

Using Regular Mail (US Postal Service) OR Using Special Mail (FedEx, UPS, etc.)

Federal Aviation Administration
Aerospace Medical Certification Division
AAM313
Civil Aerospace Medical Institute
PO BOX 25082
Oklahoma City, OK 73125-9867

Federal Aviation Administration
Aerospace Medical Certification Division
AAM313
Civil Aerospace Medical Institute, Bldg. 13
6700 S. MacArthur Blvd., Room 308
Oklahoma City, OK 73169

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☐ 1. Provider printed name_____ phone _____

☐ 2. Date of last clinical encounter for Diabetes _____

☐ 3. Date of most recent DIABETES MEDICATION **CHANGE** _____
And describe what was changed:

☐ 4. Quarterly hemoglobin A1c
(A1c's must be done ≥ 30 days after meds change and ≤ 90 days of recertification.)

| Quarterly A1Cs | Value | Date |
|---|---|---|
| #1 | | |
| #2 | | |
| #3 | | |
| #4 | | |

☐ 5. Review the blood glucose self-monitoring log book, recording device download, or continuous glucose monitoring (CGM) data, if used. Comment on stability, variance (highs and lows), and any other concerns you have. If control is good and there are no concerns, state that also.

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**In lieu of #6 and #7, the physician's office may attach a current medication list. The list should note for what condition the medications are used.**

☐ 6. List Insulin treatment schedule:

_____

_____

_____

_____

☐7. List **ALL** other current medications* (for any condition) and why they are used/diagnosis treated. Dosage is not required.

_____

_____

_____

_____

**IF YES on any of the questions below, please attach narrative, tests, etc.**

☐8. Any side effects from medications.....Yes No

☐9. ANY episode of hypoglycemia in the past year
**REQUIRING ASSISTANCE** from another person.....Yes No

☐10. Any evidence of progressive diabetes induced end organ disease:

Cardiac.....Yes No
Neurological.....Yes No
Ophthalmological .....Yes No
Neuropathy .....Yes No
Renal disease .....Yes No

☐11. Any clinical concerns or other comments? .....Yes No

_____ _____

Treating Provider Signature Date

For more information, see:

- Acceptable Combinations of Diabetes Medications
- Pharmaceuticals (Therapeutic Medications) - Diabetes Mellitus - Insulin Treated