SIX-MINUTE WALK TEST (6MWT) - FAA RESULT SHEET
(Updated 08/25/2021)

NAME___________________________________________ DOB__________________________________
APPLICANT ID#___________________________________ PI#___________________________________

Please have the provider who treats your cardiac or pulmonary condition complete this sheet. The test must
be done in accordance with the American Thoracic Society (ATS) Guidelines for the Six-Minute Walk Test.
(Note: Link must be opened in Google Chrome.)

Submit this sheet and any other supporting documentation 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. Treating provider’s printed name: ____________________________ Phone number: ________________

2. List ALL current cardiopulmonary medications:_______________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

TEST RESULTS (For YES or NO questions, please circle answer.)

3. Did the airman complete Six-Minute Walk Test? YES or NO. If YES, total distance walked _____ meters.

4. Did the airman stop or pause before 6 minutes? YES or NO. If YES, reason(s):____________________
______________________________________________________________________________________

5. If stopped or paused, total time walked: _________ (min/sec); total distance walked: _________ meters.

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<tr>
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<th>Baseline</th>
<th>End of 1 minute</th>
<th>End of 2 minutes</th>
<th>End of 3 minutes</th>
<th>End of 4 minutes</th>
<th>End of 5 minutes</th>
<th>End of 6 minutes</th>
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<tbody>
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<td>HEART RATE</td>
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<td>Scale of 0 to 5 (none to severe)</td>
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6. Supplemental oxygen used during the test: YES or NO. If YES, flow ________ (L/min)

7. Rescue inhaler used shortly before or during test: YES or NO.

8. Other symptoms at end of test (e.g. angina; leg/hip/calf pain; dizziness, etc.)
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

9. Treating provider’s interpretation and comments:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Treating provider’s signature ________________________________ Date of evaluation _______________