

# OSA STATUS REPORT- INITIAL (Page 1 of 2)

(Updated 02/23/20221)

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Applicant ID# \_\_\_\_\_

PI# \_\_\_\_\_

Please have your treating physician complete this report with the requested information. Submit either this status report or a clinic note from your physician detailing **ALL** of the information below. **Include initial sleep study** report and, **if treated with PAP device(s), include a copy of the most recent PAP download(s)**. 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** diagnostic sleep study.....

2. Type of study (in-lab type I or home type II, III, or IV).....

3. **Is the PRIMARY diagnosis Obstructive Sleep Apnea (OSA)?**.....  
If **NO**, list diagnosis (e.g. central sleep apnea, restless legs syndrome (RLS), narcolepsy, insomnia, etc.)\_\_\_\_\_

4. Any evidence of sleep-disruptive RLS.....

5. Periodic limb movements per hour (number).....

6. Central apneas or central hypopneas per hour (number).....

7. Percentage of total apnea and hypopnea episodes that are central.....

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

9. Does the airman have other conditions that may be associated w/increased risk for OSA?.....  
If **YES**, circle any applicable conditions below:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>a. Atrial Fibrillation or arrhythmia</li> <li>b. Congestive heart failure</li> <li>c. Coronary Artery Disease (CAD)</li> <li>d. Diabetes</li> <li>e. Hypertension (Treatment refractory; incomplete blood pressure control on 3 or more medication components.)</li> <li>f. Obesity</li> </ul> | <ul style="list-style-type: none"> <li>g. Stroke</li> <li>h. Other _____</li> </ul> |
|---|---|

10. **What is the recommended treatment?** (Circle all that apply)

- a. PAP (CPAP/BiPAP/APAP). (For FAA purposes, PAP device is required for **AHI 16 or higher**.)
- b. Dental device
- c. Nerve stimulator device
- d. Surgical intervention
- e. Weight loss, positional therapy (conservative management)
- f. Other
- g. No treatment indicated

/ /	
Yes	No*
No	Yes*
%	
No	Yes*

## OSA STATUS REPORT- INITIAL (Page 2 of 2)

(Updated 02/23/2022)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Applicant ID# \_\_\_\_\_ PI# \_\_\_\_\_

11. Does the airman use any sleep or sedating medications? .....  
 (e.g. zolpidem, eszopiclone, trazodone, ropinirole, gabapentin, pramipexole, diphenhydramine.)  
 If YES, list medication name, dosage, frequency, and reason for use. \_\_\_\_\_

12. If treatment **other** than PAP used, list type → then go to Question 18.....

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

13. Date range of use.....

14. 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.\* .....  
 \*FAA medical certification is based on treatment for 365 days or 30 days for newly diagnosed/ treated. If less time represented, describe. \_\_\_\_\_

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

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

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

→ 18. Is current treatment effective\* with good control of symptoms, good compliance with therapy, and should be continued?.....  
 \*Subjective screen (Epworth or similar), objective data (residual AHI and device leak, if applicable), and clinical exam reveal NO concern for residual daytime sleepiness.

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

No	Yes*
Type of treatment used	
From	To
# of days actually used	# of days covered in report
Percentage days used	
Hours	Minutes
AHI	
Yes	No*

\_\_\_\_\_ Treating physician signature

\_\_\_\_\_ Date

Note: This OSA INITIAL 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 - Initial or a clinical note (with ALL required information) from your physician;
- A copy of your most recent sleep study (used for diagnosis); 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.