

OSA STATUS REPORT- INITIAL (Page 1 of 2)
(Updated 08/28/2024)

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 leg 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:

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

- a. Atrial Fibrillation or arrhythmia
 - b. Congestive heart failure
 - c. Coronary Artery Disease (CAD)
 - d. Diabetes
 - e. Hypertension
(Treatment refractory; incomplete blood pressure control on 3 or more medication components.)
 - f. Obesity

- g. Stroke
 - f. Other _____


- 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

OSA STATUS REPORT- INITIAL (Page 2 of 2)
(Updated 08/28/2024)

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.** AHI with treatment.....
Note: **5 or less** is acceptable. If AHI is 6 or higher on treatment, 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 on treatment	
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.