

**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  | g. Stroke      |
| b. Congestive heart failure   | f. Other _____ |
| c. Coronary Artery Disease (CAD)  |                |
| d. Diabetes   |                |
| e. Hypertension   |                |
| (Treatment refractory; incomplete blood pressure control on 3 or more medication components.) |                |
| f. Obesity  |                |

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

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**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.