

**AIRMAN COMPLIANCE WITH TREATMENT  
OBSTRUCTIVE SLEEP APNEA (OSA)**

I \_\_\_\_\_ (print name) certify that (check one):

\_\_\_ I have been using \_\_\_\_\_ (CPAP/ Dental / or Positional Device) for OSA as prescribed. I am tolerating the therapy well and have no symptoms of OSA (e.g. daytime sleepiness or lack of mental attention or concentration).

\_\_\_ I have been surgically treated for OSA and I have no symptoms of OSA (e.g. daytime sleepiness or lack of mental attention or concentration).

I understand and acknowledge that I will receive the new requirements for continuation of my special issuance of Obstructive Sleep Apnea and I will comply with the requirements at my next FAA medical certificate renewal or reapplication.

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reference Number: (PI, MID, or APP ID): \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_