

## **Diabetes on Oral Medication – FAA Recertification Form**

1) Patient Name:	DOB:	
2. Provider Printed Name: Phone:		ne:
3. Date of last clinical encounter for Diabetes:		_
4. Date of most recent Diabetes Medication Change: _		
5. Hemoglobin A1C Lab Value: and (more than 30 days after medication changes and with		
6. List all medication Airman is currently taking for ar	ny condition:	
If YES on any of the questions below, please attach na	arrative, tests, et	·C.
7. Any side effects from medications	YES	NO
8. Any episode of hypoglycemia in the past year?	YES	NO
9. Any evidence of progressive diabetes induced end of	organ disease	
Cardiac	YES	NO
Neurological	YES	NO
Ophthalmological	YES	NO NO
Peripheral neuropathy Renal Disease	YES YES	NO NO
10. Does this paitent take ANY form of insulin?	YES	NO
11. Any clinical concerns?	YES	NO
Treating Provider Signature	Date	

150 KENNEDY DRIVE SOUTH BURLINGTON, VERMONT 05403 802-448-9370 802-448-1414(F)