"We exist to serve our patients with compassionate health care of the highest quality."

Obstructive Sleep Apnea Compliance Form

Name: ____

Driver's License Number: ____

The section below needs to be complete by the physician treating you for your sleep disorder.

1. A list of conditions and current medications the patient is currently prescribed for wakefulness, alertness or sleep:

   ____

   ____

   ____

2. The driver is getting adequate hours of nightly CPAP usage.

   _______True _______False

3. The driver is getting adequate sleep hours in general.

   _______True _______False

4. The driver's symptoms of sleepiness have been resolved.

   _______True _______False

5. Your professional opinion on the following:

   a. This driver's sleep disorder is satisfactorily controlled

   _______True _______False

   Comments ____

   ____

   ____

   b. The sleep disorder(s) is (are) not adversely affecting the driver's ability to operate a commercial motor vehicle.

   _______True _______False

   Comments ____

   ____

   ____

Doctor's Signature ____

Doctor's Printed Name ____

Date ____________________ Doctor's License Number ____________________

Phone Number ____

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