



SLEEP APNEA
TREATMENT COMPLIANCE FORM
DEPARTMENT OF TRANSPORTATION

NAME \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_

This section needs to be completed by your physician treating you for your sleep apnea.

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

[ ] True [ ] False

[ ] Comments:

\_\_\_\_\_

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

[ ] True [ ] False

[ ] Comments:

\_\_\_\_\_

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

[ ] True [ ] False

[ ] Comments:

\_\_\_\_\_

4. 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 License Number: \_\_\_\_\_ Phone # \_\_\_\_\_