Diabetes on Oral Medication – FAA Recertification Form

1) Patient Name: _____ DOB:_____

2. Provider Printed Name: _____ Phone: _____

3. Date of last clinical encounter for Diabetes: _____

4. Date of most recent Diabetes Medication Change: _____

5. Hemoglobin A1C Lab Value:_____ and date done: _____
(more than 30 days after medication changes and within 90 days of recertification)

6. List all medication Airman is currently taking for any condition:

If YES on any of the questions below, please attach narrative, tests, etc..

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 organ disease		
Cardiac	YES	NO
Neurological	YES	NO
Ophthalmological	YES	NO
Peripheral neuropathy	YES	NO
Renal Disease	YES	NO
10. Does this paitent take ANY form of insulin?	YES	NO
11. Any clinical concerns?	YES	NO

_____ _____
Treating Provider Signature Date

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