Driver Responsibility Agreement

I, _____ (print driver's name), **IF** I have been found to have obstructive sleep apnea (OSA) or a sleep-disordered breathing disorder that requires treatment, a therapy device will be provided. Once I have been given a Positive Airway Pressure (PAP) device and masks, and have received training, if needed, in how to use the device, masks, and related equipment, and maintain them in good working order, with tips on how to adjust to therapy. Support contact info is below.

For all questions or problems with my PAP device or supplies, I will call my Sleep Apnea Counselor at: Compliance Support SSD | 855.723.3378 EXT. 2

I understand that it is **my personal responsibility** to manage and keep track of my compliance with therapy, using the **device a minimum of 4 hours per day for 70 percent of days**, including vacation and personal time.

Based on the recommendations by the Medical Review Board, drivers being treated for OSA with PAP therapy who do not comply with therapy (4 hours per day for 70 percent of days) after the first week of assistance, may be considered not medically qualified.

I understand that consistent use of the device will help to improve my health and may reduce fatigue. Failure to use the PAP device consistently will increase my health risks and risk for accidents.

Driver Signature: _____ Date:_____

Witness Signature: _____ Date:_____

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