

**Date:** [Insert Date]

**To:** [Recipient Name/Organization]

**Attention:** [Department Name, e.g., Safety/Medical Records]

**Fax/Email:** [Recipient Contact Info]

**Subject: Verification of CPAP Compliance for [Patient Name]**

To Whom It May Concern,

This letter is to certify that **[Patient Name]**, Date of Birth: **[DOB]**, is currently under my care for the treatment of Obstructive Sleep Apnea (OSA).

The patient has been prescribed Positive Airway Pressure (PAP) therapy. I have reviewed the usage data from the patient's device for the period of **[Start Date]** to **[End Date]**. The data indicates the following:

- **Compliance Status:** [Compliant / Non-Compliant]
- **Average Usage:** [Number] hours per night
- **Percentage of Nights Used:** [Number]% (minimum 4 hours per night)
- **Current AHI (Apnea-Hypopnea Index):** [Number]

Based on the clinical data, the patient is responding well to therapy, and their condition is being managed effectively. **[Patient Name]** is cleared to perform **[Job Duties/Driving/General Tasks]** from a sleep health perspective, provided they continue consistent use of the device.

If you require further information or a full download of the compliance report, please contact my office at **[Phone Number]**.

Sincerely,

[Doctor's Signature]

**[Doctor's Name, Degree]**

[Facility/Clinic Name]

[NPI Number]