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AFFIDAVIT OF INTOLERANCE OR NON-COMPLIANCE TO CPAP

I, _____, have been informed/attempted to us CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- ☐ An inability to get the mask to fit properly
- ☐ Disturbed or interrupted sleep caused by the prescence of the device
- ☐ Noise level from the device disturbing sleep or bed partner's sleep
- ☐ CPAP restricted movement during sleep
- ☐ Mask/Nasal accessory leaking beyond comfort
- ☐ Discomfort caused by the straps and headgear
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Latex allergy
- ☐ Claustrophobic associations
- ☐ Other _____

Due to my intolerance/inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device.

Signature _____

Date _____