**BILL WOLFE, D.D.S., PA**

**3915 BRISTOL HWY. SUITE 103**

**JOHNSON CITY, TN. 37601**

**(423)461-0073**

**AFFIDAVIT FOR INTOLERANCE TO CPAP**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_ Mask leaks**

 **\_\_\_\_\_\_\_ Mask uncomfortable/device uncomfortable**

 **\_\_\_\_\_\_\_ Unable to sleep comfortably**

 **\_\_\_\_\_\_\_ Noise disturbs my sleep and or bed partner’s sleep**

 **\_\_\_\_\_\_\_ Restricts movement during sleep**

 **\_\_\_\_\_\_\_ Does not seem to be effective**

 **\_\_\_\_\_\_\_ Straps/headgear cause discomfort**

 **\_\_\_\_\_\_\_ Pressure on upper lip causes tooth related problems**

 **\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment, which is ORAL AIRWAY DILATOR APPLIANCE, as prescribed to me by dr. Bill Wolfe.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**