

PATIENT'S NAME: _____ DOB: _____

CACI - Hypertension Worksheet (Updated 6/24/15)

The Examiner should review a current status report by the treating physician and any supporting documents to determine the applicant's eligibility for certification. HOWEVER, the AME is not required to review a current status report from the treating physician IF the AME can otherwise determine that the applicant has had stable clinical blood pressure control on the current antihypertensive medication for at least 7 days, without symptoms from the hypertension or adverse medication side-effects, and no treatment changes are recommended. If the applicant **meets ALL the acceptable certification criteria** listed below, the Examiner can issue. Applicants for first- or second- class must provide this information annually; applicants for third-class must provide the information with each required exam.

AME MUST REVIEW	ACCEPTABLE CERTIFICATION CRITERIA
Treating physician or the AME finds the condition stable on current regimen for at least 7 days and no changes recommended	<input type="checkbox"/> Yes
Symptoms	<input type="checkbox"/> None
Blood pressure in office	<input type="checkbox"/> Less than or equal to 155 systolic and 95 diastolic (Although 155/95 is acceptable for certification, the airman should be referred to their primary provider for further management, if the blood pressure is above clinical practice standards)
Acceptable medication(s) See <u>Pharmaceutical</u> section for additional information.	<input type="checkbox"/> Combinations of up to 3 of the following: Alpha blockers, Beta-blockers, calcium channel blockers, diuretics, ACE inhibitors, ARBs, direct renin inhibitors, and/or direct vasodilators are allowed. NOT acceptable: Centrally acting antihypertensives
Side effects from medications	<input type="checkbox"/> No

AME MUST NOTE in Block 60 one of the following:

- CACI qualified hypertension.
- Not CACI qualified hypertension. Issued per valid SI/AASI. (Submit supporting documents.)
- NOT CACI qualified hypertension. I have deferred. (Submit supporting documents.)

PHYSICIAN'S STAMP

PHYSICIAN'S SIGNATURE:

DATE: