



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE IN POLYSOMNOGRAPHY

Documents needed for licensure as a technologist

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must be written within the last six months and contain original signatures.
3. Attachment 1 – Verification of Education
4. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
5. Attachment 3 – Verification of credentialing and exam scores.
6. Attachment 4 – Verification of supervising physician.
7. Fees - \$200.00 plus \$10.00 state regulatory fee. Total amount **\$210.00**. All fees are non-refundable.
8. For initial licensure in Tennessee applicants must obtain a criminal background check. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>.
9. Attachment 5 – Declaration of Citizenship

Documents needed for temporary licensure as a technician

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must contain original signatures.
3. Attachment 1 – Verification of Education.
4. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
5. Attachment 4 – Verification of supervising physician.
6. Fees - \$200.00 plus \$10.00 state regulatory fee. Total amount **\$210.00**. All fees are non-refundable.
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8. Attachment 5 – Declaration of Citizenship

Persons currently enrolled in a sleep study program

1. Please fill out "Letter of Notification" **only**. [Click Here](#) for document.

UNDERSTANDING THE APPLICATION PROCESS

1. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Medical Examiners'
Polysomnography Professional Standards Committee
665 Mainstream Drive
Nashville, TN 37243**

2. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the Committee office every consideration in this matter.
3. If necessary documentation has not been received when your application has been received by the Committee office, an initial deficiency letter will be sent to you by mail. The supporting documentation requested in the letter must be received in the Committee office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.
4. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination. Application approval may also be accessed through our webpage at www.tennessee.gov/health and click on licensure verification.
5. It is recommended that you do not make arrangements to accept employment as a Polysomnography Technologist in Tennessee until you are granted a license by the Board of Medical Examiners' Polysomnography Professional Standards Committee.
6. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners'
Polysomnography Committee
665 Mainstream Drive
Nashville, TN 37243

For Federal Express or Special Courier:
Tennessee Board of Medical Examiners'
Polysomnography Committee
665 Mainstream Drive
Nashville, TN 37228

The application form is not acceptable if any portion of it or any other documents required to be submitted by the rules or the application itself has been executed and dated prior to one year before filing with the Committee.

IMPORTANT: After July 1, 2010 you must have either a Tennessee License or a Board issued authorization in your possession before you can lawfully practice.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

For Official Use Only

3202-001 \$200.00
3202-006 \$ 10.00



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APPLICATION FOR LICENSE AS A POLYSOMNOGRAPHIC TECHNOLOGIST/TECHNICIAN

Name _____
(First) (Middle and/or Maiden) (Last)

Date of Birth _____ Social Security # _____
(Month) (Day) (Year)

Current Home Mailing Address _____ Current Practice Address _____

Home Phone (_____) _____ Work Phone (_____) _____

Please indicate the type of license for which you are applying.

- _____ Technologist
- _____ Technician (Temporary License – **not for use if currently enrolled in sleep study program**)
- _____ Grandfather TCA 63-31-106(c)

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of [this page](#) if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		Educational Institution	Location

Please complete your entire employment history starting with the most current position first. Use the back of [this page](#) if you need additional space.

DATES

LOCATION

From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties
From: _____ Mo/Yr	To: _____ Mo/Yr	_____	_____
		City/State	Position/Duties

CERTIFICATION INFORMATION

List below ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED as a polysomnographic technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below ALL states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a polysomnographic technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice your profession”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, and to learn and keep abreast of developments in your profession;
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.
3. **“Chemical substances”** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
4. **“Currently”** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee or within the past two (2) years.
5. **“Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS

Yes No

- | | | | |
|----|--|-------|-------|
| 1. | Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? | _____ | _____ |
| a. | If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? | _____ | _____ |
| b. | If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? | _____ | _____ |

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS	Yes	No
2. Do you currently use chemical substances as defined on the previous page? If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety? Please list: _____ _____	_____ _____	_____ _____
3. Are you currently engaged in the illegal use of controlled substances? If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____ _____	_____ _____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice as a polysomnographer in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
9. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

ATTACHMENT 1



**STATE OF TENNESSEE
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www.tennessee.gov/health

EDUCATION VERIFICATION

APPLICANT: Supply the information requested and then mail this entire form to the school at which you completed your training.

Please check one of the following:

_____ I graduated from a polysomnographic educational program that is accredited by the commission on accreditation of allied health education programs;

_____ I graduated from a respiratory care educational program that is accredited by the commission on accreditation of allied health education programs and completed the curriculum for a Polysomnography certificate established and accredited by the committee on accreditation for respiratory care of the commission on accreditation of the allied health education programs;

_____ I graduated from an electroneurodiagnostic technologist educational program with a polysomnographic technology track that is accredited by the commission on accreditation of allied health education programs; or,

_____ I successfully completed an accredited sleep technologist educational program (A-STEP) that is accredited by the American Academy of Sleep Medicine.

NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

Full Name: _____ (Last) (First) (Middle/Maiden)
Social Security Number: _____ - -
Student Identification Number: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a polysomnographer in the State of Tennessee. Please forward a certificate of completion, diploma or final official transcript along with this form to the Board of Medical Examiners' Polysomnography Professional Standards Committee, 665 Mainstream Drive, Nashville, TN 37243. (37228 for courier service only)

Thank you for your cooperation and prompt response.

Applicant's Signature

Date



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www.tennessee.gov/health
CLEARANCE FROM OTHER STATE BOARDS

Please complete the top portion of this form and forward it to the regulatory board in each state where you hold or have held a license to practice any profession. (This form may be duplicated.)

NOTE: Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

I was granted a license or certificate to practice _____ numbered _____
on _____ by the State of _____
Date

The Tennessee Board of Medical Examiners' Polysomnography Professional Standards Committee request that I submit evidence that my certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to: Tennessee Board of Medical Examiners' Polysomnography Professional Standards Committee, 665 Mainstream Drive, Nashville, Tennessee 37243.

Date: _____ Signature: _____
SSN: _____ Printed Name: _____

THIS PORTION IS TO BE COMPLETED BY STATE REGULATORY BOARD

License Number: _____ Date Issued: _____
Profession: _____

Basis of Issuance: _____ Endorsement/Reciprocity With: _____
Written Examination: _____
(Provide Description of Exam)

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No

If "yes", please attach explanation.

Authorized Signature Title Date

ATTACHMENT 3



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www.tennessee.gov/health

BOARD OF REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS VERIFICATION

Only if or when you are credentialed with the BRPT, please complete this form and mail it to the address below:

**BOARD OF REGISTERED POLYSOMNOGRAPHIC
TECHNOLOGISTS**
Credentiaing and Program Manager
8400 Westpark Drive, 2nd Floor
McLean, VA 22102

Website: www.brpt.org Phone: (703) 610-9020 Fax: (703) 610-0229

To Be Completed By Applicant (Please Print In Ink)

Dear BRPT Official:

I am applying for a license to practice as a Polysomnographer in the State of Tennessee. The State Board of Medical Examiners' Polysomnography Professional Standards Committee requires that a credential letter be **forwarded directly to their** office by the BRPT.

Applicants Name: _____
First Middle Last

Did you pass the national certifying exam? _____ Credential #: _____
Yes No

I do hereby authorize you to release the information requested to the Committee office.

Signature

Date

PLEASE MAIL VERIFICATION DIRECTLY TO:

**Board of Medical Examiners' Polysomnography Professional Standards Committee
665 Mainstream Drive
Nashville, Tennessee 37243**



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SUPERVISION NOTIFICATION

**This section must be completed by the supervising physician.
(This page may be duplicated if necessary)**

List all practice settings:

1) Setting:

Supervisor's Signature

Printed Name

Practice Setting

Tennessee License Number

2) Setting:

Supervisor's Signature

Printed Name

Practice Setting

Tennessee License Number

3) Setting:

Supervisor's Signature

Printed Name

Practice Setting

Tennessee License Number

4) Setting:

Supervisor's Signature

Printed Name

Practice Setting

Tennessee License Number

ATTACHMENT 5



STATE OF TENNESSEE
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DECLARATION OF CITIZENSHIP

MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

- 1. Name: Last First Middle Maiden
- 2. Mailing Address:
- 3. Phone Number: Home: () - Office: () - Fax: () -
- 4. I am a United States Citizen: Yes No
- 5. I am a foreign national not physically present in the United States Yes No. If you answered yes to this question, please sign this form in the presence of a notary and return it with your application. No further documentation is required.
- 6. Applicants Claiming United States Citizenship MUST provide one of the following: a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety. b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria. c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify. d) A federally issued birth certificate. e) A valid, unexpired U.S. passport. f) A report of birth abroad of a U.S. citizen. g) A certificate of citizenship. h) A certificate of naturalization. i) A U.S. citizen ID card. j) Any successor document to #'s e-i above. k) An SSN that is verifiable with the Social Security Administration in accordance with federal law.
- 7. If you checked "No" in question 4, please indicate from the list below which category applies to you: (circle one) a) Permanent Resident b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 et seq.). c) Asylees who meet the qualifications set out in 8 U.S.C. 1158.

- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157.
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980.
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

.....
ALL APPLICANTS MUST SIGN AND HAVE NOTARIZED

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20____.

 Signature

Sworn to before me this ____ day of _____, 20____.

 NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.