Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF MEDICINE

NEW LICENSE/REGISTRATION APPLICATION FOR POLYSOMNOGRAPHY

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to ***DC Code 22-2514***. If you have any questions, call HPLA Customer Service at **1-877-672-2174 Monday through Friday, 8:30AM to 4:40PM EST.**

SECTION 1 REGISTRATION TYPE & FEES:

SELECT LICENSE/REGISTRATION TYPE:	FEES:	
☐ Polysomnographic Technologist (RPSGT)	RPSGT: ☐ $230.00	Criminal Background Check
☐ Polysomnographic Technician (CPSGT)	CPSGT: ☐ $230.00	☐ $ 50.00 (If processed through the District) *Exceptions may apply.
☐ Polysomnographic Trainee	Trainee: ☐ $100.00	

SECTION 2A. APPLICANT INFORMATION:

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

DEGREE(S): _____

____/_____/_____ _____ - _____ - _____
Date of Birth **Social Security Number**

GENDER: ☐ **MALE** ☐ **FEMALE**

SECTION 2B. OTHER NAMES USED: (Please print clearly)

If your name has changed at any point since you attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____
Place of Birth : State/Providence/Territory **Country if not USA**

SECTION 2C. RACE & ETHNICITY DESIGNATION: (Optional)

☐ **American Indian/Alaskan Native** ☐ **Asian/South Asian**

☐ **Black or African American** ☐ **Caucasian/White**

☐ **Hispanic or Latino** ☐ **Other** _____

☐ **Native Hawaiian or other Pacific Islander**

(See instructions for detailed definitions)

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

_____

_____

_____

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SECTION 3A. PREFERRED MAILING ADDRESS:

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 3B. HOME ADDRESS:

THIS INFORMATION WILL NOT BE MADE AVAILABLE TO THE PUBLIC.

HOME ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **HOME PHONE NUMBER: (**_____**)** _____ **-** _____ **HOME FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____

SECTION 3C. BUSINESS ADDRESS:

THIS INFORMATION WILL BE MADE AVAILABLE TO THE PUBLIC.

BUSINESS NAME:_____

BUSINESS ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

☐ **SUITE #**_____ ☐ **FLOOR#**_____

BUSINESS PHONE NUMBER: (_____**)** _____ **-** _____ **BUSINESS FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____

IMPORTANT MESSAGE TO ALL POLYSOMNOGRAPHERS

Polysomnographers are required to update name or address changes within 30 days of the change. It is imperative that you update your information in writing, by email **hpla.doh.dc.gov or fax (202) 724-5145** to the District of Columbia Health Professional Licensing Administration Processing Department. Submit your request to the Attention of the "Processing Center". Include your name, phone number and any other pertinent information that will assist us in ensuring that the information is updated to the appropriate record/file.

District of Columbia Health Professional Licensing Administration
Attention: Processing Department – Board of Medicine
899 North Capitol St. NE 1st Floor
Washington, D.C. 20002

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SECTION 4A. SECONDARY EDUCATION / TRAINING INSTITUTIONS :

Secondary school attendance and Adult and Pediatric Basic Life Support (Cardio-Pulmonary Resuscitation) certification.

I. Have you completed secondary school? Yes: ___ No: ___ **If yes**, please provide the information below.

Type (Diploma, GED, Equivalent, etc.):_____ Date of Completion:_____

Name and location of School: _____

II. Do you hold a current Adult and Pediatric Basic Life Support (CPR) certification? Yes: ____ No: ____

If yes, please indicate the source and provide the certification expiration date:

_____ American Red Cross - Expiration Date_____
_____ American Heart Association – Expiration Date _____
_____ Other _____ - Expiration Date _____

SECTION 4B. POLYSOMNOGRAPHY TRAINING AND POLYSOMNOGRAPHY PRACTICE:

List experience covering the five (5) year period prior to the submission of the application (**MONTH & YEAR**). Include letters from employing facilities and organizations. **For "TRAINING AND PRACTICE DESCRIPTIONS", use the letter key code below**. List experience in reverse chronological order, beginning with the most recent.

Organization/Institution	Start Date mm/yyyy	End Date mm/yyyy	Type of Position *(Use Key Code Below)*

TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE

A. Training **B.** Employment **C.** Other

(**Attach a typed explanation on a separate sheet of paper to this form.**)

SECTION 4C. POLYSOMNOGRAPHY LICENSES/REGISTRATIONS IN OTHER STATES/JURISDICTIONS:

List all states and jurisdictions in which you have ever held a license.

Are you currently applying for licensure in any other jurisdiction? _____ If yes please list:_____

List all states and jurisdictions in which you have ever held a license. **Jurisdiction**	Issue Date mm/yyyy	Expiration Date mm/yyyy	License Number

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SECTION 5 REQUIRED SCREENING QUESTIONS:		
Please answer questions A through O by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper attaching copies of all relevant documents such as final court orders or panel review decisions.**		
A.	Have you ever been arrested, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations)?	**Yes** ☐ **No** ☐
B.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). **HEALTH PROFESSION(S)** _____ _____ **JURISDICTION(S)** _____ _____	**Yes** ☐ **No** ☐
C.	Have you been a defendant or respondent to a claim for damages or a malpractice action?	**Yes** ☐ **No** ☐
D.	Have you ever voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges have been brought against you or while you were under investigation?	**Yes** ☐ **No** ☐
E.	Have you ever surrendered your clinical privileges (voluntary or involuntary) or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	**Yes** ☐ **No** ☐
F.	Have you ever been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	**Yes** ☐ **No** ☐
G.	Has any licensing authority taken adverse action against your license or privileges or informed you of any pending charges?	**Yes** ☐ **No** ☐
H.	Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you?	**Yes** ☐ **No** ☐
I.	Are you presently or have you ever been under a corrective action plan imposed by an employer, medical facility or educational program?	**Yes** ☐ **No** ☐
J.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice your profession safely or that could affect your performance or impact your ability to practice your profession?	**Yes** ☐ **No** ☐
K.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	**Yes** ☐ **No** ☐
L.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	**Yes** ☐ **No** ☐
M.	Within the last ten (10) years, have you been terminated, asked to resign, disciplined or voluntarily resigned by any employer due to practice issues or moral turpitude issues?	**Yes** ☐ **No** ☐

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N.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	Yes ☐ No ☐
O.	Have you ever had a professional liability policy cancelled or not renewed?	Yes ☐ No ☐

SECTION 6A. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Keep a photocopy.

☐ **Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back.** ***The photos must be original photos and cannot be computer-generated copies or paper copies.***

☐ **One (1) character reference form-** ***Please have form completed by your supervisor.***

☐ **Verification(s) of licensure** – ***These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license identified in Section 4C.***

☐ **All academic transcripts.**
Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed in Section 4A.

☐ **Document all experience covering the five (5) year period prior to the submission of the application, following completion of school for appropriate profession.** - ***Proof of experience should be submitted as a letter on official letterhead from the overseeing institution(s)/organization(s).***

☐ **Credentials from the Board of Registered Polysomnographic Technologists or appropriate accrediting body** – ***These should be provided in a sealed envelope from the examination contractor or administrator.***

☐ **Documentation of current certification in Cardio Pulmonary Resuscitation (CPR).**

☐ **Criminal Background Check**

SECTION 6B. PAYMENT/MAILING INFORMATION

*Make **CHECK** or **MONEY ORDER** payable to:*
DC Treasurer.
A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

MAIL YOUR APPLICATION PACKAGE TO:
District of Columbia Department of Health
Health Professional Licensing Administration
Board of Medicine – Processing Center
899 North Capitol Street NE
Washington, DC 20002

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SECTION 6C.

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 8*** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 9*** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 2, Chapter 18*** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to ***D.C. Official Code Title 50, Chapter 23*** (Traffic Adjudication)?

Yes ☐ **No** ☐

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (***D.C. Law 11-118, D.C. Code §47-2861 et seq***.).

SECTION 7 LICENSEE AFFIDAVIT

NEW LICENSE/REGISTRATION APPLICATION FOR POLYSOMNOGRAPHY

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____	_____	_____
LICENSEE SIGNATURE	***PRINT NAME***	***DATE***