



**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:**

<b>SELECT LICENSE/REGISTRATION TYPE:</b> <input type="checkbox"/> Polysomnographic Technologist (RPSGT) <input type="checkbox"/> Polysomnographic Technician (CPSGT) <input type="checkbox"/> Polysomnographic Trainee	<b>FEES:</b> <b>RPSGT:</b> <input type="checkbox"/> \$230.00 <b>CPSGT:</b> <input type="checkbox"/> \$230.00 <b>Trainee:</b> <input type="checkbox"/> \$100.00	<b>Criminal Background Check</b> <input type="checkbox"/> \$ 50.00 (If processed through the District)
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**SECTION 2A. APPLICANT INFORMATION:**

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

\_\_\_\_\_  
**Place of Birth : State/Providence/Territory**                      **Country if not USA**  
**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.)**

**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

**LANGUAGE(S) SPOKEN:**

*Language(s) spoken other than English:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





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**SECTION 4A. ACADEMIC/TRAINING INSTITUTIONS :**

List schools attended pertaining to your profession, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

**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. <b>Jurisdiction</b>	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 <input type="checkbox"/> <input type="checkbox"/>
B.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). <b>HEALTH PROFESSION(S)</b> _____ <b>JURISDICTION(S)</b> _____	Yes No <input type="checkbox"/> <input type="checkbox"/>
C.	Have you been a defendant or respondent to a claim for damages or a malpractice action?	Yes No <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
F.	Have you ever been terminated or resigned (voluntary or involuntary) from a clinical or professional training program for any reason?	Yes No <input type="checkbox"/> <input type="checkbox"/>
G.	Has any licensing authority taken adverse action against your license or privileges or informed you of any pending charges?	Yes No <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/>
O.	Have you ever had a professional liability policy cancelled or not renewed?	Yes No <input type="checkbox"/> <input type="checkbox"/>



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**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 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).
- Delegation Agreement (Trainee and Technician)
- 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 Health Professional Licensing  
Administration  
Attention: Processing Department – Board of Medicine  
899 North Capitol St. NE 1<sup>st</sup> Floor  
Washington, D.C. 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 APPLICANT AFFIDAVIT**

*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.*

\_\_\_\_\_  
**APPLICANT SIGNATURE**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**DATE**