

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH**



**District of Columbia
Polysomnographic Supervisory Delegation Agreement Form**

This document is to be filed with the Board of Medicine. A duplicate copy is to be kept on site at the primary place of practice. It is to be updated as necessary, no less frequently than annually. The Delegation Agreement must be signed by the supervising physician(s) (MD/DO) or Polysomnographic Technologist(s) (RPSGT).

***Use section IV on page 2 if there is the need to amend the Delegation Agreement through the addition or deletion of a supervising physician/polysomnographic technologist.**

SECTION I. POLYSOMNOGRAPHIC TRAINEE/TECHNICIAN

A. Identification and Contact

1. Name of Trainee/Technician: _____
2. Address: Street # _____ City _____ State _____ Zip Code _____
3. Contact: Daytime Phone # _____ Email _____
4. Training Status: ___ Graduate Student ___ Post-Graduate ___ Trainee Applicant ___ Technician Applicant.

B. Training Requirement Being Fulfilled (Only Complete the Applicable Parts)

1. If supervision fulfills a **CAAHEP student requirement**:
 - a. Name of Current Institution: _____
 - b. Name of Program Clinical Coordinator: _____(Credit for successful completion of the supervised experience will be assigned to:
 - c. Course name: _____
 - d. Course number: _____
2. If supervision fulfills an **ASTE requirement**:
 - a. Name of Degree/Certificate Granting Institution: _____
 - b. Name of Program: _____
3. If supervision fulfills a **technician requirement**:
 - a. Name of Degree/Certificate Granting Institution: _____

SECTION II. SUPERVISORY PHYSICIAN/ POLYSOMNOGRAPHIC TECHNOLOGIST INFORMATION

A. Identification and Contact

1. Name: _____
Supervising Physician / Polysomnographic Technologist
2. Institution/Organization: _____
3. Address: _____ City _____ State _____ Zip Code _____
4. Contact: Daytime Phone #: _____ Email: _____

B. Supervised Training Arrangements

1. Date supervised practice to begin: _____
2. Supervision arrangement expected to continue how long? _____ weeks, _____ months, _____ year(s)
3. Supervision expected to end (approximate date) _____
4. Number of hour's supervisee will practice under supervision: _____ hours; per _____ week or _____ month

5. Supervisee will receive ___ hour(s) of individual immediate supervision per ___ (week)
6. Location(s) where immediate supervision will be provided:
- a. Name: _____ a. Address: _____
- b. Name: _____ b. Address: _____
- c. Name: _____ c. Address: _____

SECTION III. SUPERVISED PRACTICE INFORMATION/DELEGATION OF DUTIES

A. Supervised Practice Activities/Responsibilities: Check each that applies (and provide description where requested)

1. Patient Interviewing & Explaining Procedures _____ Children _____ Adolescents _____ Adults
2. Polysomnography Sensor & Electrode Application _____ Children _____ Adolescents _____ Adults
3. Conduct Polysomnographic Recordings _____ Children _____ Adolescents _____ Adults
4. Conduct CPAP Mask Interface Fittings _____ Children _____ Adolescents _____ Adults
5. Apply CPAP _____ Children _____ Adolescents _____ Adults
6. Other (e.g., Training) _____ please describe _____
 Briefly describe (including typical goals, methods, clients and frequency of activities):

7. Likely diagnostic classifications of clients/patients (check each that applies):

- Insomnia
- Sleep Related Breathing Disorders
- Periodic Limb Movement Disorders
- Parasomnias
- Hypersomnia's
- Circadian Rhythm Sleep Disorders
- Sleep Related Movement Disorders
- Other: Specify: _____

SECTION IV. TRAINEE/TECHNICIAN SUPERVISING PHYSICIAN/POLYSOMNOGRAPHIC TECHNOLOGIST

A. Name of Supervisor

1. Name: _____ Date _____
 Supervising Physician / Polysomnographic Technologist
2. Name: _____ Date _____
 Supervising Physician / Polysomnographic Technologist
3. Name: _____ Date _____
 Supervising Physician / Polysomnographic Technologist

B. Location (of Practice)

1. Practice Name _____
 Department _____
 Address _____
 Phone number _____
2. Practice Name _____
 Department _____
 Address _____
 Phone number _____

3. Practice Name _____
 Department _____
 Address _____
 Phone number _____

**SECTION V. SUPERVISING PHYSICIAN/POLYSOMNOGRAPHIC TECHNOLOGIST(S)
 AVAILABILITY**

- A. A Supervising physician/technologist must be available to the trainee/technician in person or via electronic communications. Describe when and how the supervising physician/technologist is available to the trainee/technician while the trainee/technician provides patient care. Describe situations when the trainee/technician might be caring for patients while the supervisor is away from the site. For these situations delineate how physician/technologist will be available to supervise the trainee/technician, taking into account the skills and the experience of the trainee, and the acuity of patient problems seen in the practice.

SECTION VI. QUALITY ASSURANCE

- A. Describe the process by which the supervising physician/technologist will evaluate the trainee's/technician's practice, appropriate to the setting and consistent with current standards of acceptable medical practice. (Eg. quarterly chart reviews of the most difficult cases indicated by a note in the chart by the supervising physician/technologist and a follow up chart review log.)

- B. Attach additional pages to describe provisions unique to your practice.

SECTION VII. SIGN AND DATE

Sign and date this form.

 Polysomnographic Trainee/Technician Date _____
 DC license number

 Print Name

 Supervising Physician/Polysomnographic _____
 Technologist Date _____
 DC license number

 Print Name

Additions to Supervising Physician/Polysomnographic Technologist list

(1) Printed Name

(1) DC license number

(1) Signature of Supervising Physician/Technologist

(1) Date

(2) Printed Name

(2) DC license number

(2) Signature of Supervising Physician/Technologist

(2) Date

(3) Printed Name

(3) DC license number

(3) Signature of Supervising Physician/Technologist

(3) Date

Deletions to Supervising Physician/Polysomnographic Technologist list

(1) Printed Name

(1) DC license number

(1) Signature of Supervising Physician/Technologist

(1) Date

(2) Printed Name

(2) DC license number

(2) Signature of Supervising Physician/Technologist

(2) Date

(3) Printed Name

(3) DC license number

(3) Signature of Supervising Physician/Technologist

(3) Date
