New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Polysomnography
124 Halsey Street, 6th Floor, P.O. Box 45051
Newark, New Jersey 07101
(973) 273-8093

Instructions for Reinstating/Reactivating a License

In accordance with the Uniform Enforcement Act, a professional or occupational license or certificate may be reinstated/reactivated, provided that the applicant otherwise qualifies for licensure, registration or certification and complies with the provisions of N.J.S.A. 45:1-7.2a, b, c and d. The necessary application and materials for applying for reinstatement/reactivation are enclosed.

1. **Complete and return:**
   - The enclosed Application for Reinstatement/Reactivation.
   - The enclosed Authorization Form for a Criminal History Background Check.

2. **Enclose:**

   For reinstatements
   - Payment of a reinstatement fee of $175.00; and
   - Payment of the appropriate renewal fee ($500.00 for technologists or $150.00 for technicians).

   For reactivation
   - Payment of $500.00 (technologists) or $150.00 (technicians) for the ***current*** licensure period.

3. **Submit:**
   a. A signed and dated certification of employment listing each job held during the lapsed licensure or certification period. This certification of employment must include the names, addresses and telephone numbers of each employer. ***(If you are currently unemployed or employed in a setting which is clearly unrelated to the field of polysomnography, please indicate this fact.)***
   b. Proof that you completed the continuing education credits required for each biennial licensure period during which the license was not active.
   c. A written request to the Board indicating why you are able to recommence acting as a trainee, technician or technologist, as appropriate.
   d. Proof that you hold current certification in Basic Life Support for the Healthcare Provider from the American Heart Association or Cardio Pulmonary Resuscitation/Automated External Defibrillator (C.P.R./A.E.D.) for the Professional Rescuer from the American Red Cross.
   e. If you are a trainee or a technician, proof that you will be supervised by a licensed polysomnographic technologist or a licensed physician while acting as a polysomnographic trainee or technician.
   f. If you are a technician seeking to reinstate your license, you must provide proof that you completed 100 sleep studies in a facility that is provisionally or fully accredited by A.A.S.M.

Note

A licensee whose license has been automatically suspended (expired) for more than five (5) years who wishes to return to practice shall reapply for licensure and shall demonstrate that he or she has maintained proficiency in the field of polysomnography. An applicant who fails to demonstrate to the satisfaction of the Board that he or she has maintained proficiency while the license was lapsed may be subject to an examination or other requirements as determined by the Board prior to reinstatement/reactivation of his or her license (N.J.A.C. 13:44L-3.2(f)).

4. **Mail to:** State Board of Polysomnography
   P. O. Box 45051
   Newark, NJ 07101

Upon review and approval of your reinstatement/reactivation application and criminal history background check results, a license or certificate will be issued.

Attach a clear, full-face passport photograph (2″x2″) of your head and shoulders, **taken within the past six months**.

A photo is required with each application.

Do not use staples to attach the photo.

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Please indicate below the type of action you wish to initiate.

- ☐ Reinstatement
- ☐ Reactivation

Application for Reinstatement/Reactivation of a License

N.J. License/Certificate No.:_____ Type of License/Certificate: _____

Initial License/Certificate Date: _____ Year of last renewal: _____

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

1. Name _____ (_____)
Last name First name Middle initial Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

_____ _____
Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

_____
Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in the denial of reinstatement/reactivation of licensure or certification.

*Social Security Number: _____-_____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7, 60.8 and 60.9, the Board is required to obtain your Social Security number. Pursuant to these authorities, the Board is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

- ☐ U.S. citizen
- ☐ Alien lawfully admitted for permanent residence in U.S.
- ☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Child Support

Please certify, under penalty of perjury, the following:

a.	Do you currently have a child-support obligation?	☐ Yes	☐ No	
	(1) If "Yes," are you in arrears in payment of said obligation?	☐ Yes	☐ No	
	(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months?	☐ Yes	☐ No	
b.	Have you failed to provide any court-ordered health insurance coverage during the past six months?	☐ Yes	☐ No	
c.	Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding?	☐ Yes	☐ No	
d.	Are you the subject of a child-support-related arrest warrant?	☐ Yes	☐ No	

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to questions a(1) through d may result in a denial of reinstatement/reactivation of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____	_____	_____
Applicant's name (please print)	Applicant's signature	Date

6. Illegal Use of Controlled Dangerous Substances

The question below pertains to the illegal use of controlled dangerous substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer this question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis on the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law, (N.J.S.A. 45:1-20).

"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 may have an ongoing impact on one's functioning as a licensee, or within the previous 365 days, whichever is longer.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Are you currently engaged in the illegal use of controlled dangerous substances? (As stated above, "currently" is defined as "recently enough… [to] have an ongoing impact…" or "within the previous 365 days," whichever is longer.)

☐ Yes ☐ No

If you answered "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 engaging in the illegal use of controlled dangerous substances?

☐ Yes ☐ No

_____ _____

Applicant's signature Date

7. Have you ever changed your name? ☐ Yes ☐ No
   If "Yes," please submit with this application a copy of the marriage certificate, divorce decree or court order.

8. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

9. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

   If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

10. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name.

    _____ _____ _____
    Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

11. Have you ever been disciplined or denied a license or certificate to practice polysomnography, or any other type of professional license or certificate in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

12. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Have you ever been named as a defendant in any litigation related to the practice of polysomnography or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of polysomnography or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 11 through 17, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Employment since your license expired or became inactive.

(You may photocopy this page if necessary.)

Employer: ______________________________

Address: ______________________________
Street address City State ZIP code

Telephone number: ______________ ***(include area code)*** Hours per week: ______________

Your major responsibilities (use additional sheets of paper if necessary):

Employed from ______________ to ______________
Month Year Month Year

Immediate supervisor's name: ______________________________

Employer: ______________________________

Address: ______________________________
Street address City State ZIP code

Telephone number: ______________ ***(include area code)*** Hours per week: ______________

Your major responsibilities (use additional sheets of paper if necessary):

Employed from ______________ to ______________
Month Year Month Year

Immediate supervisor's name: ______________________________

Employer: ______________________________

Address: ______________________________
Street address City State ZIP code

Telephone number: ______________ ***(include area code)*** Hours per week: ______________

Your major responsibilities (use additional sheets of paper if necessary):

Employed from ______________ to ______________
Month Year Month Year

Immediate supervisor's name: ______________________________

______________ ______________ ______________
Applicant's name (please print) Applicant's signature Date

Continuing Education

Please list all of the courses that you have successfully completed since your license expired or became inactive. In addition, you must provide a copy of the Certificate of Completion for every course you have taken.

Date	Title	Subject matter	Sponsor	No. of hours

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____
Date

_____
Signature of applicant

Certification for Reinstatement/Reactivation Application

I, _____ , in making this application to the Board for reinstatement/reactivation of certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny reinstatement/reactivation or to withhold renewal of or suspend or revoke a certificate or license issued by the Board.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for reinstatement/reactivation. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Date Signature of applicant

Official Use Only

☐ Dual License

License Type 1

_____

Applicant's Number

_____

License Type 2

_____

Applicant's Number

_____

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Official Use Only

☐ Resubmit

_____

Board or Committee

_____

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____ / _____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is $18.75.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

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Sleep Studies for Technologist Reinstatement

I attest that _____ (Name of applicant) has completed _____ (No. of studies) sleep studies as a licensed polysomnographic technician over the last _____ (No. of months) months beginning _____ (MM/DD/YY) ending _____ (MM/DD/YY)

at _____ (Name of facility) , _____ (Street address, City, ZIP code)

_____ (Telephone number - include area code) which is provisionally or fully accredited by the American Academy of Sleep Medicine (AASM).

_____
Print name of licensed polysomnography technologist
or qualified medical director

_____ _____
Signature of licensed polysomnography technologist or qualified medical director — Date (MM/DD/YY)

_____ _____
License number of licensed polysomnography technologist or qualified medical director — Date of license expiration (MM/DD/YY)

Please note:

N.J.A.C. 13:44L-1.2 defines a "qualified medical director" as a licensed physician who is either eligible for board certification or is board certified in sleep medicine by the American Board of Sleep Medicine, or a certification board recognized by the American Board of Medical Specialties which bases its certification in sleep medicine upon the sleep medicine examination created by the American Board of Internal Medicine, and who acts as the medical director of any:

1. In-patient or out-patient sleep center or laboratory provisionally accredited or fully accredited by the AASM or accredited by a Joint Commission;
2. Ambulatory care facility or general acute care hospital licensed by the Department of Health and Senior Services;
3. Home health agencies, assisted living residences, comprehensive personal care homes, assisted living programs and alternate family care sponsor agencies licensed by the Department of Health and Senior Services; or
4. Health care service firms registered with the Division of Consumer Affairs.

N.J.A.C. 13:44L-3.3(c)4 Documentary proof signed by a supervising polysomnographic technologist or qualified medical director indicating that, within the last year, the applicant has completed at least 100 sleep studies in a facility that is provisionally or fully accredited by AASM.

(Attach additional copies as necessary.)

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Technician/Trainee Supervision Form

To be completed by the supervisor of each facility.
A supervisor is defined as a licensed polysomnographic technologist or a qualified medical director (as defined in N.J.A.C. 13:44L-1.2).

_____, who is licensed as a physician or polysomnographic
(Name of supervisor)

technologist in New Jersey, will act as primary supervisor for _____
(Name of applicant)

and is aware that he or she, or another physician or polysomnographic technologist licensed in New Jersey, shall be continuously on-site and available, either on-site or through voice or electronic communication whenever

_____is acting as a polysomnographic technician/trainee.
(Name of applicant)

_____will maintain a record of the name and license number of the licensed
(Name of supervisor)

physician or polysomnographic technologist/trainee who is supervising _____
(Name of applicant)

while he or she is acting as a polysomnographic technician/trainee.

_____ _____
Print name of supervisor Name of applicant

_____ _____
Signature of supervisor Signature of applicant

_____ _____
Date Date

_____
License number of supervisor

Facility's name: _____

Facility's address:_____
Street City State ZIP code

Facility's telephone number: _____ (include area code)

(Attach additional copies as necessary.)