

Attach a clear, full-face passport-style photograph (2"x 2") 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.



**New Jersey Office of the Attorney General**

Division of Consumer Affairs  
State Board of Polysomnography  
124 Halsey Street, 7th Floor, P.O. Box 45051  
Newark, New Jersey 07101  
(973) 273-8093

Date received: \_\_\_\_\_  
Date of examination: \_\_\_\_\_

**Polysomnography Technician - Temporary License**  
**(Applicant does not hold a Polysomnographic Trainee's License.)**

Date: \_\_\_\_\_

Please enclose an application filing fee of \$100.00 and a license fee of \$150.00 (for a total of \$250.00) in the form of a check or money order made out to the State of New Jersey. (Applicants should understand that if the fees are paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fees are paid.)

If the application process is not completed within one year, your application will be discarded and you will need to re-apply with full payment.

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

Place of birth: \_\_\_\_\_  
City State

1. Name  Mr. \_\_\_\_\_ ( \_\_\_\_\_ )  
 Mrs. \_\_\_\_\_  
 Ms. \_\_\_\_\_  
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



## 7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical 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 those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity 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 of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

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

**“Ability to practice as a polysomnography technician”** is to be construed to include all of the following:

- The cognitive capacity to exercise the reasonable judgments of a polysomnography technician and to learn and keep abreast of professional developments; and
- The ability to communicate those judgments and related information to clients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and
- The physical capability to perform the duties of a polysomnography technician, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

**“Chemical substance”** 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.

**“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 two years.

**“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.

- Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?  Yes  No
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program\*\*?  Yes  No  Not applicable
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice?  Yes  No  Not applicable
- Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety?  Yes  No  Not applicable
- Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?  Yes  No
- Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that “currently” is defined as “within the last two years.”)  Yes  No

If you answered “Yes” to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?  Yes  No

\*\* If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized 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 or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

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Signature of applicant

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Date

8. 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.

9. 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
_____	_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired
_____	_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired
_____	_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired
_____	_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired

10. Have you ever been disciplined or denied 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

11. 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

12. 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

13. 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

14. 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

15. 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.)

16. 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

17. 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

18. 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 10 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

## Technician Education - No Trainee's License

1. Did you graduate from high school?  Yes  No

a) If "Yes," what was the date of your graduation? \_\_\_\_\_  
Month Year

b) What years did you attend high school? \_\_\_\_\_

c) What is the name of the high school you attended? If you did not graduate from a high school, do not list any school.

\_\_\_\_\_  
Name of high school

(If you have graduated from a high school, arrange for the school to forward proof of graduation directly to the State Board of Polysomnography.)

If "No," did you study to receive a General Educational Development (G.E.D.) certificate?  Yes  No

If you have not graduated from high school, submit proof that you hold a G.E.D. certificate.

Provide the name of the Commission on the Accreditation of Allied Health Education Programs (CAAHEP) accredited polysomnographic course that you completed as well as the name and address of the entity that offered the course.

\_\_\_\_\_  
Name of course

\_\_\_\_\_  
Dates attended

\_\_\_\_\_  
Name and address of entity offering CAAHEP-accredited polysomnographic course

Arrange for the CAAHEP-accredited polysomnographic course to forward proof of completion directly to the State Board of Polysomnography.

## Basic Life Support

You must provide proof that you hold a current (not expired) certification in Basic Life Support for the Health Provider from the American Heart Association or Cardio Pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) for the Professional Rescuer from the American Red Cross.

Please provide a copy (front and back) of your certification.

# AFFIDAVIT

**This affidavit is to be executed by the applicant before a notary public:**

State of: \_\_\_\_\_

County of: \_\_\_\_\_

} ss.

I, \_\_\_\_\_, in making this application to the State Board of Polysomnography, for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the State Board of Polysomnography, swear (or affirm) that I am the applicant and that all 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 licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:14G-1 et seq., together with the Rules and Regulations of the State Board of Polysomnography, N.J.A.C. 13:44 et seq., and fully understand that in receiving licensure or certification from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. 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.

\_\_\_\_\_  
Signature of applicant

Sworn and subscribed to before me this \_\_\_\_\_

day of \_\_\_\_\_, \_\_\_\_\_  
Month Year

\_\_\_\_\_  
Name of Notary Public (please print)

\_\_\_\_\_  
Signature of Notary Public



**Official Use Only**

Dual License

License Type 1

Applicant's Number

License Type 2

Applicant's Number



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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. \_\_\_\_\_ Last First Middle Maiden Name  
 Ms.

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 \$25.30. (Beginning on March 19, 2012, this fee will be reduced to \$22.55.)** 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.

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Signature of applicant

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Date



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**Technician 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.  
(Name of applicant)

\_\_\_\_\_ will maintain a record of the name and license number of  
(Name of supervisor)  
the licensed physician or polysomnographic technologist who is supervising \_\_\_\_\_  
(Name of applicant)

while he or she is acting as a polysomnographic technician.

\_\_\_\_\_  
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.)**