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, 6th Floor, P.O. Box 45051
Newark, New Jersey 07101
(973) 273-8093

Date received: _____

Date of examination: _____

Polysomnography Technologist - Not Licensed as a Polysomnographic Technician

Date: _____

A nonrefundable application filing fee of $100.00 and a license fee of $500.00 (for a total of $600.00) in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (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.)

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

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal 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 or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee 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 **(You must answer a, b, c and d.)**

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 any of the questions a(1) through d will result in a denial 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. 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

9. 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

10. 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

11. 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

12. 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

13. 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

14. 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.)

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 9 through 17, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Technologist Education without a Technician's License

1 a. 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

b. Please arrange for the CAAHEP-accredited polysomnographic course to forward proof of completion **directly** to the State Board of Polysomnography, P.O. Box 45051, Newark, NJ 07101.

Applicants with a Doctorate Degree in a Health-Related Field*

2. For individuals who possess a doctorate degree in a health-related field, you may also fulfill the requirements for licensure if you:

   a) Sucessfully completed the examination administered by BRPT, having completed a minimum of six months of paid clinical experience where at least 21 hours per week per calendar year of on-the-job polysomnography duties were performed as direct patient recording and/or scoring within the three years immediately prior to taking the examination; or

   b) Sucessfully completed the examination administered by the American Board of Sleep Medicine between 1978 and 2006, having attained the status of Diplomate of the American Board of Sleep Medicine.

   * *A health-related field means any field in which services are rendered or research is conducted for the purpose of maintaining or restoring an individual's physical or mental health. Examples would include, but are not limited to, fields such as medicine, dentistry, optometry, nursing, physical therapy, respiratory therapy, and psychology.*

Verification of RPSGT Credentials

3. Please arrange for the Board of Registered Polysomnographic Technologists to submit evidence that you have successfully completed the certification examination **directly** to the State Board of Polysomnography, P.O. Box 45051, Newark, NJ 07101.

   By E-mail (preferred)

   In order to expedite processing of your application - you can have the BRPT e-mail the State Board of Polysomnography verification of your RPSGT credential. Please e-mail the BPRT at info@brpt.org.

   Please be sure to type **RPSGT verification** in the Subject line of your e-mail.

   Include the following information in the Body of your e-mail:

   Your Full Name

   Your RPGST Credential Number

   I am requesting that the BRPT please forward verification of my RPSGT credential to the State Board of Polysomnography at njpolysomnography@dca.lps.state.nj.us

   By U.S. Mail

   You can write to BRPT and have your official Board of Registered Polysomnographic Technologists verification sent **directly** to the Board office at: State Board of Polysomnography, P.O. Box 45051, Newark, New Jersey 07101.

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 (AHA) or Cardio Pulmonary Resuscitation/Automated External Defibrillator (CPR/AED) for the Professional Rescuer from the American Red Cross, or another entity determined by the Department of Health to comply with AHA CPR Guidelines.

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. 13:44L-1.1 through 6.1, 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

Affix Seal Here

Official Use Only
☐ Dual License
License Type 1
_____
Applicant's Number
_____
License Type 2
_____
Applicant's Number
_____

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

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.

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

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

Verification of Hospital/Medical Employment, Privileges or Appointment

Applicant's Name: _____

Name of Hospital/Facility: _____

Hospital/Facility Address: _____

Hospital/Facility Telephone Number: _____

1. What position did this health practitioner hold at your facility? _____
2. What were this health practitioner's dates of employment at your facility? _____
3. Was this health practitioner on probation, suspended, sanctioned or in any way sanctioned/disciplined while at your facility? ☐ Yes ☐ No
4. Was this health practitioner granted a leave of absence while employed at your facility? ☐ Yes ☐ No
5. Were any restrictions placed on this health practitioner's activities which were not placed on all other employees holding similar positions? ☐ Yes ☐ No
6. Were any restrictions placed on this health practitioner's privileges? ☐ Yes ☐ No
7. Were any formal patient or staff complaints filed against this health practitioner? ☐ Yes ☐ No
8. Were any incident reports filed involving the professional conduct or behavior of this health practitioner? ☐ Yes ☐ No
9. Was this health practitioner ever subject to nonroutine monitoring while in your facility? ☐ Yes ☐ No
10. Was this health practitioner involuntarily removed from a call schedule for cause? ☐ Yes ☐ No
11. Was this health practitioner ever subject to nonroutine quality assessment review? ☐ Yes ☐ No
12. Was this health practitioner the subject of a negative review by a quality assurance or departmental committee? ☐ Yes ☐ No
13. Was this health practitioner the subject of an investigation by your facility or any committee or department of your facility? ☐ Yes ☐ No
14. Were any malpractice actions filed naming this health practitioner as a defendant that involved his or her period of employment at your facility? ☐ Yes ☐ No

If you have answered **"Yes"** to any of the questions above, please explain: _____

_____

_____

15. Did this health practitioner leave your facility in good standing? ☐ Yes ☐ No

16. Would you consider re-hiring this health practitioner for a position at your facility? ☐ Yes ☐ No

17. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

If you have answered **"No"** to questions 15, 16 or 17, please explain: _____

_____

_____

18. Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

_____

Print the name and title of certifying official:_____

Signature of certifying official:_____

Date form was completed :_____

NOTE: Please attach letterhead or a business card from the facility where the applicant worked or supply some form of identification for the individual supplying information.

SEAL OF HOSPITAL
(If Applicable)

PLEASE RETURN DIRECTLY TO:

State Board of Polysomnography
124 Halsey Street, 6th Floor,
P.O. Box 45051
Newark, New Jersey 07101

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

License/Certification Verification Request

Directions: Complete only the top portion of this license/certification form and forward it to the license/certification agency in the state in which you are licensed/certified. The agency should complete the form and return it to the State Board of Polysomnography. Note: Be advised that the agency completing the form may charge a fee for license/certification verification. Please call the agency to check on fees for license/certification verification prior to submitting this form.

Name: _____
First Name Middle Name Last Name Maiden Name, if applicable

Name on original license/certification: _____ Telephone number: _____
(include area code)

Current address: _____
Street City State ZIP code

License/Certification number: _____ Year issued: _____

This section is to be completed by the state licensing/certification agency.

1. License/Certification number: _____ Date issued: _____
2. When was the license/certificate last renewed? _____
3. Is the license/certificate in good standing? ☐ Yes ☐ No
4. Has this license/certification ever been revoked, suspended or voluntarily surrendered or has any action been taken by your agency against this licensee? ☐ Yes ☐ No

   If "Yes," please provide a description of the reason and/or charge(s) and any action(s) taken and provide a copy of any complaint, order or relevant document.

_____

_____

_____

_____

I certify that the statements contained herein are true based upon official records that I reviewed.

Official Seal

Print Name _____
Signature _____
Title _____
State _____ *Date* _____

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

Military Service Profile

Completed this form if you would like the Board to consider the education, training oe experience you received while serving as a member of the Armed Forces towards fulfilling the requirements for licensure.

Applicant's name:_____

Applicant's rank :_____

Branch of service:_____

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the **State Board of Polysomnography, 124 Halsey Street, 6th Floor, P.O. Box 45051, Newark, New Jersey 07101.** Please include a copy of the applicant's Verification of Military Experience and Training (VMET) Form 2586, or any successor form, and the applicant's Joint Services Transcript detailing the education/training the applicant received while in the military. Your early attention is appreciated.

_____ _____
Applicant's signature Date

1. What position and rank does this individual hold or did he/she hold when discharged?

   _____

   _____

2. What were this individual's dates of service?_____

3. What type of discharge did this individual receive?_____

   A. What was the date of discharge?_____

4. Was the individual on probation, suspended or in any way sanctioned/disciplined while in the military? ☐ Yes ☐ No

5. Was this individual granted a leave of absence while in the military? ☐ Yes ☐ No

6. Were any restrictions placed on this individual's activities which were not placed on all other personnel holding similar positions? ☐ Yes ☐ No

7. Would this individual be recommended for re-enlistment? ☐ Yes ☐ No

   If "No," please explain._____

   _____

8. Would this individual be recommended for promotion? ☐ Yes ☐ No

   If "No," please explain._____

   _____

9. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No

If "Yes," please explain._____

_____

10. Was this individual in the Medical Corps? ☐ Yes ☐ No

If "Yes," please answer questions A-H:

A. Was this individual denied clinical privileges while in the military? ☐ Yes ☐ No

B. Were any restrictions placed on this individual's clinical privileges? ☐ Yes ☐ No

C. Were any formal patient or staff complaints filed against this individual? ☐ Yes ☐ No

D. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No

E. Was this individual ever subject to nonroutine monitoring while in the military service? ☐ Yes ☐ No

F. Was this individual removed from a call schedule for cause? ☐ Yes ☐ No

G. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No

H. Would you recommend this individual for privileges at a hospital? ☐ Yes ☐ No

Please supply any additional comments or information that the Board or Committee should consider prior to determining this applicant's eligibility for licensure.

_____

_____

Please print the name of the individual supplying the information: _____

Signature of the individual supplying the information: _____

Address and full telephone number where the individual supplying the information may be contacted:

_____

_____

_____

Date form was completed: _____

Please return directly to:

State Board of Polysomnography
124 Halsey Street, 6th Floor
P. O. Box 45051
Newark, NJ 07101

Please Affix Official Seal Here