STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

TENNESSEE BOARD OF RESPIRATORY CARE
(615) 253-5087 OR 1-800-778-4123 ext 3-5087
www.tennessee.gov

INSTRUCTIONS TO ACCOMPANY APPLICATION FOR ENDORSEMENT BY THE BOARD OF RESPIRATORY CARE TO PERFORM POLYSOMNOGRAPHY SERVICES

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive an endorsement by the Tennessee Board of Respiratory Care to provide polysomnographic services pursuant to Tenn. Code Ann. Sect. 63-31-107(a)(5). Application material is available on line at: www.tennessee.gov.

1. Obtain a copy of the Application for Endorsement by the Board of Respiratory Care to Perform Polysomnography Service. Identify for the board's administrative staff which type of endorsement you seek and check the appropriate box. Complete the personal information portion of the Application.

2. If you are applying for endorsement by examination and are credentialed by the National Board for Respiratory Care (NBRC) please so indicate on the application and complete Attachment 1. You must provide Attachment 1 to the NBRC and request that a verification of your credential as a sleep disorders specialist be forwarded directly to the board's administrative office.

3. If you are applying for endorsement by examination and are credentialed by the Board of Registered Polysomnographic Technologists (BRPT) please so indicate on the application and complete Attachment 2. You must provide Attachment 2 to the BRPT and request that a verification of your credential as a registered polysomnographic technologist be forwarded directly to the board's administrative office.

4. If you are applying for endorsement pursuant to the "training pathway" please so indicate on the application and complete Attachment 3, Verification of Competency in Polysomnography. You must provide the information requested in the top box and then mail that form to each institution/sleep facility in which you have worked and/or trained. If you have worked and/or trained in more than one institution/sleep facility, you will need to copy the form, fill out the top box and provide it to each.

5. You will need the institution/sleep facility in which you trained to fill out the bottom portion of Attachment 3, have it **notarized** and returned to the board's administrative office along with the completed Attachment A, Institution/Sleep Facility Competency Checklist.

6. All documents are required to be submitted by you or by appropriate institution in this application process mailed directly to:

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

7. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

8. If necessary documentation has not been received when your application has been received by the board's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. **(Files not completed within ninety (90) days may be closed.)**

9. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

10. **If an address change occurs at any time during the application process, you must notify the Board's administrative office in writing immediately.**

11. It is recommended that you do not make arrangements to accept employment which requires you to perform polysomnographic services until you are endorsed by the Board of Respiratory Care.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

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APPLICATION FOR ENDORSEMENT BY THE BOARD OF RESPIRATORY CARE TO PERFORM POLYSOMNOGRAPHY SERVICES

PLEASE CHECK THE APPROPRIATE CATEGORY FOR WHICH YOU ARE APPLYING:

☐ ENDORSEMENT BY EXAMINATION BY BRPT ☐ ENDORSEMENT BY EXAMINATION BY NBRC

☐ ENDORSEMENT BY TRAINING PATHWAY

PERSONAL INFORMATION
Please Print In Ink

Name: _____
Last First Middle Maiden

Mailing Address: _____

Phone Number: Home: (___)_____-_____ Office: (___)_____-_____

Applicant's Registered Respiratory Therapist License Number:_____ Date Issued: _____

Applicant's Certified Respiratory Therapist License Number:_____ Date Issued: _____

I AM APPLYING FOR ENDORSEMENT BY EXAMINATION: ☐ **yes** ☐ **no**

I hold the SDS by the NBRC: ☐ **yes** ☐ **no**
If yes, please complete **Attachment 1** in its entirety.

I am credentialed by the BRPT: ☐ **yes** ☐ **no**
If yes, please complete **Attachment 2** in its entirety.

I am requesting the Board of Respiratory Care to consider granting me an endorsement to perform polysomnography services pursuant to its training pathway. ☐ **yes** ☐ **no**

If yes, please complete **Attachment 3** in its entirety. **Attachment A (competency check list) must accompany Attachment 3.**

_____ _____
Applicant's Signature Date

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS

665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

TENNESSEE BOARD OF RESPIRATORY CARE
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VERIFICATION OF SLEEP DISORDER SPECIALTY CREDENTIAL FROM THE NATIONAL BOARD FOR RESPIRATORY CARE

ONLY IF YOU ARE LICENSED BY THE BOARD OF RESPIRATORY CARE **AND** WISH TO BE ENDORSED TO PERFORM POLYSOMNOGRAPHY SERVICES, PLEASE FILL OUT THIS FORM AND MAIL IT TO:

NBRC Executive Office
18000 W. 105th Street
Olathe, KS 66061-7543
(913) 895-4900
Enclose appropriate fee:
$5 Active $20 Inactive

TO BE COMPLETED BY THE APPLICANT:

Dear NBRC Official:

I am applying to be endorsed to perform polysomnography services by the Tennessee Board of Respiratory Care. The Board of Respiratory Care **requires** that I be credentialed as a sleep disorders specialist by the National Board for Respiratory Care **and** that a credential letter be forwarded directly to their office by the NBRC.

Applicant's Name: _____
(First) (Middle) (Last)

Social Security Number: _____-_____-_____. Credential Number: _____

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

State of Tennessee
Department of Health
Health Related Boards
Administrative Office,
Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

TENNESSEE BOARD OF RESPIRATORY CARE
(615) 253-5087 OR 1-800-778-4123 ext 3-5087
www.tennessee.gov

VERIFICATION OF CREDENTIAL FROM THE BOARD OF REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS (BRPT)

ONLY IF YOU ARE LICENSED BY THE BOARD OF RESPIRATORY CARE **AND** WISH TO BE ENDORSED TO PERFORM POLYSOMNOGRAPHY SERVICES, PLEASE FILL OUT THIS FORM AND MAIL IT TO:

BRPT
8400 Westpark Drive
2nd Floor
McLean, VA 22102
(703) 610-9020
No Fee Required

TO BE COMPLETED BY THE APPLICANT:

Dear BRPT Official:

I am applying to be endorsed to perform polysomnography services by the Tennessee Board of Respiratory Care. The Board of Respiratory Care **requires** that I be credentialed as a registered polysomnographic technologist by the Board of Registered Polysomnographic Technologists **and** that a credential letter be forwarded directly to their office by the BRPT.

Applicant's Name: _____
(First) (Middle) (Last)

Social Security Number: ____-____-____. Credential Number: _____

PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:

State of Tennessee
Department of Health
Health Related Boards
Administrative Office,
Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

Thank you for your assistance.

ATTACHMENT 3

TENNESSEE BOARD OF RESPIRATORY CARE
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VERIFICATION OF COMPETENCY IN POLYSOMNOGRAPHY

Applicant: Provide the information requested in the top box and then mail this form to each institution/sleep facility in which you have worked and/or trained. If you have worked and/or trained in more than one institution/sleep facility, you will need to copy this form, fill out the top box and provide it to each.

Institution/Sleep Facility Administration: I am applying for an endorsement to provide polysomnographic services pursuant to a "training pathway" as authorized by Tenn. Code Ann. Sect. 63-31-107(a)(5). I hereby authorize you to release any and all information in your files concerning my competency to provide polysomnography services to the Board of Respiratory Care.

Applicant's Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Tennessee Respiratory Care License Number:_____ Date Issued: _____

Name of Institution/Sleep Facility:_____

Address: _____

_____ _____
Applicant's Signature Date

Administrative Office of Institution/Sleep Facility: NOTE: This form MUST be Notarized: Please complete and return to:

State of Tennessee, Board of Respiratory Care
227 French Landing, Heritage Place Metro Center, Suite 300
Nashville, TN 37243

I have read the attached Competency Check List and affirm the following:

_____ (Name of Applicant) was employed and/or trained at the Institution/Sleep Facility identified above and that he/she is competent in the areas affirmatively identified on the attached Competency Check List.

Applicant was at this institution/sleep facility from _____ to _____.
(Mo/Yr) (Mo/Yr)

I recommend the applicant to be endorsed to provide polysomnography services: _____Yes _____ No

I certify the information on this form to be true and correct.

_____ _____
Signature of Director of Institution/Sleep Facility Date

Subscribed and sworn to by me this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires:_____ (Affix Seal Here)

ATTACHMENT A

INSTITUTION/SLEEP FACILITY
COMPETENCY CHECKLIST

PATIENT SAFETY	**PRECEPTOR TO INITIAL WHEN COMPLETE**
Verify identity of patient	_____Yes_____No
Follow universal precautions	_____Yes_____No
Attending to patient needs appropriately	_____Yes_____No
Recognizing/responding to life-threatening situations	_____Yes_____No
Comply with hazardous material handling procedure	_____Yes_____No
Take appropriate precautions to ensure electrical safety	_____Yes_____No

PATIENT RAPPORT	**PRECEPTOR TO INITIAL WHEN COMPLETE**
Uses personal communication skills to achieve patient relaxation/cooperation	_____Yes_____No
Explains the electrode application method/procedure	_____Yes_____No
Interacts at an age/mental specific level	_____Yes_____No
Maintains respect and patient confidentiality	_____Yes_____No

PATIENT PREPARATION	**PRECEPTOR TO INITIAL WHEN COMPLETE**
Obtains concise history of patient complaints as well as medication list	_____Yes_____No
Using the 10/20 Method, measures and identifies EEG landmarks	_____Yes_____No
Applies all electrodes according to montage ordered by physician in a timely manner	_____Yes_____No
Completes all paperwork/forms for study ordered	_____Yes_____No

EQUIPMENT SETUP	**PRECEPTOR TO INITIAL WHEN COMPLETE**
Verbalizes function and utilization of all recording and monitoring equipment	_____Yes_____No
Calibrates recording equipment	_____Yes_____No

EQUIPMENT MAINTENANCE AND OPERATION	**PRECEPTOR TO INITIAL WHEN COMPLETE**
Demonstrates knowledge/function of High and Low frequency filters	_____Yes_____No
Demonstrates knowledge/function of Sensitivity/Gain settings	_____Yes_____No

RECORDING	**PRECEPTOR TO INITIAL WHEN COMPLETE**
Selects montage and equipment setting specific for the type of procedure ordered	_____Yes_____No
Verifies montage and settings	_____Yes_____No
Notes ANY changes made to initial settings during recording	_____Yes_____No
Applies the principles of electronics and mathematics to recording by:	_____Yes_____No

ATTACHMENT A

Knowing how differential amplifiers work	Yes	No
Computing voltage and frequency of waveforms	Yes	No
Calculating the duration of waveforms	Yes	No
Understanding polarity of waveforms	Yes	No
Understanding impedance	Yes	No

Identify physiological and external artifacts:

Eye movement	Yes	No
Muscle	Yes	No
ECG	Yes	No
Movement	Yes	No
Respiration	Yes	No
60 Hz	Yes	No

Corrects artifact when possible	Yes	No
Monitors artifact that cannot be corrected	Yes	No
Identifies changes in patient state	Yes	No
Identifies stages of sleep	Yes	No
Identifies abnormal patterns in flow channels	Yes	No
Documents findings in writing on tech observation sheet	Yes	No
Identifies abnormal oximetry levels and ECG dysrhythmias	Yes	No
Implements corrective action or emergency procedures as appropriate, according to Institution/Facility Policies	Yes	No

TREATMENT PROCEDURES	**PRECEPTOR TO INITIAL WHEN COMPLETE**	
Applies CPAP and Bilevel according to Institution/Facility P&P	Yes	No
Appropriately fits patient with correct interface	Yes	No
Appropriately titrates patient to suitable pressures	Yes	No

Employee signature: _____ Date: _____

Preceptor signature: _____ Date: _____

Medical Director signature: _____ Date: _____