STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE

(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE IN POLYSOMNOGRAPHY

Documents needed for licensure as a technologist

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must be written within the last six months and contain original signatures.
3. Attachment 1 – Verification of Education
4. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
5. Attachment 3 – Verification of credentialing and exam scores.
6. Attachment 4 – Verification of supervising physician.
7. Fees - $200.00 plus $10.00 state regulatory fee. Total amount **$210.00.** All fees are non-refundable.
8. For initial licensure in Tennessee applicants must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.
9. Complete, sign and have notarized the Declaration of Citizenship form: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf.

Documents needed for temporary licensure as a technician

1. Completed and notarized application. Please be advised that all pages of the application must be returned.
2. Submit two (2) original letters of recommendation from health professionals on letterhead. The letters must contain original signatures.
3. Attachment 1 – Verification of Education.
4. Attachment 2 - Clearance from other state Polysomnography Licensure Boards. (Required only if licensed in other states)
5. Attachment 4 – Verification of supervising physician.
6. Fees - $200.00 plus $10.00 state regulatory fee. Total amount **$210.00.** All fees are non-refundable.
7. For initial licensure in Tennessee applicants must obtain a criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.
8. Complete, sign and have notarized the Declaration of Citizenship form: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf.

Persons currently enrolled in a sleep study program

1. Please fill out "Letter of Notification" **only.** **Click Here** for document.

UNDERSTANDING THE APPLICATION PROCESS

1. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners'
Polysomnography Professional Standards Committee
665 Mainstream Drive
Nashville, TN 37243

2. 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 appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the Committee office every consideration in this matter.

3. If necessary documentation has not been received when your application has been received by the Committee office, an initial deficiency letter will be sent to you by mail. The supporting documentation requested in the letter must be received in the Committee office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

4. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination. Application approval may also be accessed through our webpage at www.tennessee.gov/health and click on licensure verification.

5. It is recommended that you do not make arrangements to accept employment as a Polysomnography Technologist in Tennessee until you are granted a license by the Board of Medical Examiners' Polysomnography Professional Standards Committee.

6. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners'
Polysomnography Committee
665 Mainstream Drive
Nashville, TN 37243

For Federal Express or Special Courier:
Tennessee Board of Medical Examiners'
Polysomnography Committee
665 Mainstream Drive
Nashville, TN 37228

The application form is not acceptable if any portion of it or any other documents required to be submitted by the rules or the application itself has been executed and dated prior to one year before filing with the Committee.

IMPORTANT: After July 1, 2010 you must have either a Tennessee License or a Board issued authorization in your possession before you can lawfully practice.

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

For Official Use Only

3202-001	$200.00
3202-006	$ 10.00

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www.tn.gov/health

APPLICATION FOR LICENSE AS A POLYSOMNOGRAPHIC TECHNOLOGIST/TECHNICIAN

Please indicate the type of license for which you are applying.

_____ Technologist
_____ Technician (Temporary License – **not for use if currently enrolled in sleep study program**)
_____ Grandfather TCA 63-31-106(c)

Name as it will appear on license:_____
(First) (Middle) (Last)

Have you been known by any other name? Y N If yes, list names: _____
_____
_____

Date of Birth: Mo. _____ Day _____ Yr. _____ Place of Birth _____
(City) *(State or Country)*

Social Security Number: _____-_____-_____ U.S. Citizen: Y N Sex: M F

Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces or been released from active duty to a reserve component (If yes, please provide proof of same.) Y N

Are you the spouse of a member of the armed force4s who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component (If yes, please provide proof of same.) Y N

Present Mailing Address _____ Home Phone: (_____)_____- _____
_____
_____ Work Phone: (_____)_____- _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (SEND **ATTACHMENT #1** TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR PROGRAM)

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Location

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr Educational Institution Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES **LOCATION**

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

From: _____ To: _____ _____ _____
Mo/Yr Mo/Yr City/State Position/Duties

CERTIFICATION INFORMATION

List below ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED as a polysomnographic technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below ALL states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a polysomnographic technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

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

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, and to learn and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

3. **"Chemical substances"** 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.

4. **"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 or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

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

QUESTIONS	**Yes**	**No**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____

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

COMPETENCY INFORMATION CONTINUED

QUESTIONS	Yes	No
2. Do you currently use chemical substances as defined on the previous page?	____	____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
Please list: _____		
3. Are you currently engaged in the illegal use of controlled substances?	____	____
If 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 engaged in the illegal use of controlled substances?	____	____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5. If you have ever held or applied for a license or certificate to practice as a polysomnographer in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
8. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	____	____
b. Have you ever had settlement of any legal action rendered against you; or	____	____
c. Are there any legal actions pending against you or to which you are a party?	____	____
9. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____

AFFIDAVIT AND RELEASE

I, _____, of _____
(Applicant's Name) (City) (State)
being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, and agree to abide by them in the practice as a polysomnographer in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Committee may find necessary, which may include a full Board interview.

RELEASE to the Committee, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a polysomnographer.

AUTHORIZE the Committee, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications:

RELEASE from liability the Committee, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH,
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
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www.tennessee.gov/health

EDUCATION VERIFICATION

APPLICANT: Supply the information requested and then mail this entire form to the school at which you completed your training.

Please check one of the following:

_____ I graduated from a polysomnographic educational program that is accredited by the commission on accreditation of allied health education programs;

_____ I graduated from a respiratory care educational program that is accredited by the commission on accreditation of allied health education programs and completed the curriculum for a Polysomnography certificate established and accredited by the committee on accreditation for respiratory care of the commission on accreditation of the allied health education programs;

_____ I graduated from an electroneurodiagnostic technologist educational program with a polysomnographic technology track that is accredited by the commission on accreditation of allied health education programs; or,

_____ I successfully completed an accredited sleep technologist educational program (A-STEP) that is accredited by the American Academy of Sleep Medicine.

NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

Full Name: _____
(Last) (First) (Middle/Maiden)

Social Security Number: _____ - _____ - _____

Student Identification Number: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a polysomnographer in the State of Tennessee. Please forward a certificate of completion, diploma or final official transcript along with this form to the Board of Medical Examiners' Polysomnography Professional Standards Committee, 665 Mainstream Drive, Nashville, TN 37243. (37228 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature **Date**

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
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www.tennessee.gov/health

CLEARANCE FROM OTHER STATE BOARDS

Please complete the top portion of this form and forward it to the regulatory board in each state where you hold or have held a license to practice any profession. (This form may be duplicated.)

NOTE: Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

****

I was granted a license or certificate to practice _____ numbered _____
on _____ by the State of _____.
Date

The Tennessee Board of Medical Examiners' Polysomnography Professional Standards Committee request that I submit evidence that my certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to: Tennessee Board of Medical Examiners' Polysomnography Professional Standards Committee, 665 Mainstream Drive, Nashville, Tennessee 37243.

Date: _____ Signature: _____

SSN: _____ Printed Name: _____

****

THIS PORTION IS TO BE COMPLETED BY STATE REGULATORY BOARD

License Number: _____ Date Issued: _____
Profession: _____

Basis of Issuance: Endorsement/Reciprocity With: _____
Written Examination: _____
(Provide Description of Exam)

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No
If "yes", please attach explanation.

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS'
POLYSOMNOGRAPHY PROFESSIONAL STANDARDS COMMITTEE
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www.tennessee.gov/health

BOARD OF REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS VERIFICATION

Only if or when you are credentialed with the BRPT, please complete this form and mail it to the address below:

BOARD OF REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS
Credentialing and Program Manager
8400 Westpark Drive, 2nd Floor
McLean, VA 22102

Website: www.brpt.org Phone: (703) 610-9020 Fax: (703) 610-0229

To Be Completed By Applicant (Please Print In Ink)

Dear BRPT Official:

I am applying for a license to practice as a Polysomnographer in the State of Tennessee. The State Board of Medical Examiners' Polysomnography Professional Standards Committee requires that a credential letter be **forwarded directly to their** office by the BRPT.

Applicants Name: _____
First Middle Last

Did you pass the national certifying exam? _____ Yes _____ No Credential #:_____

I do hereby authorize you to release the information requested to the Committee office.

_____ _____
Signature Date

PLEASE MAIL VERIFICATION DIRECTLY TO:

Board of Medical Examiners' Polysomnography Professional Standards Committee
665 Mainstream Drive
Nashville, Tennessee 37243

ATTACHMENT 4 **Applicant's Name:**_____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

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SUPERVISION NOTIFICATION

This section must be completed by the supervising physician.
(This page may be duplicated if necessary)

List all practice settings:

1) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

2) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

3) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number

4) Setting:

_____
Supervisor's Signature

_____
Printed Name

_____
Practice Setting

_____
Tennessee License Number