ATTENTION!

Criminal History Record Checks (CHRC) are required for all applicants. The Board may not reinstate or issue a new license to any applicant, physician or allied health practitioner, if the Board has not received criminal history record information.

The Board recommends that you do not submit your fingerprints for a CHRC earlier than 45 days before the date you intend to submit your initial license or reinstatement application to the Board.

The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

For detailed instructions on submitting your fingerprints for a CHRC, please read and follow the attached instructions.

Instructions to Apply for a Criminal History Records Check

As a qualification for initial licensure, reinstatement, or registration, *individuals must* apply for a state and FBI criminal history records check (also known as CHRC or background check) through the Criminal Justice Information System (CJIS) Central Repository of the Department of Public Safety and Correctional Services (DPSCS). Individuals must submit their fingerprints to CJIS for a background check. *The Board of Physicians (the Board) may not reinstate or issue a new license or registration to any applicant or licensee if the Board has not received their CHRC information.*
Note: A CHRC is not required to renew a license or registration.

The CHRC results will be maintained in the Maryland and FBI databases for further identification. Individuals have the right to challenge their records, which is discussed in detail in the **FBI Privacy Act Statement/Noncriminal Justice Applicant's Privacy Rights notice.**

How do I submit my fingerprints for a CHRC?

1. If you reside ***within*** Maryland:
   - Go to *any* authorized location in Maryland that provides commercial fingerprinting services. For a listing of commercial fingerprinting servicers in Maryland, visit the DPSCS website at www.dpscs.state.md.us/publicservs/fingerprint.shtml.

   - ***Note:*** Before you go to a **CJIS**-operated fingerprinting service location, download and print the LiveScan pre-registration form. *Complete the form and bring it with you.* The LiveScan pre-registration form includes the Board's unique agency authorization numbers.

2. If you reside **outside** of Maryland:
   - Out-of-state individuals have the option of using a Maryland location for fingerprinting. If using a Maryland location, follow the instructions *above* for individuals *residing within Maryland*. If you're using a fingerprinting servicer outside of Maryland, you must contact CJIS and request that they mail you a fingerprint card. Please contact CJIS by:

     a. Emailing CJIS customer service at cjis.customerservice@maryland.gov, **or**
     b. Calling CJIS at 410-764-4501, or call toll-free at 1-888-795-0011.

3. Provide the fingerprinting servicer with the Board's unique agency authorization numbers and information listed below, or if applying by mail, write the following information on your fingerprint cards:

   a. CJIS state authorization #: 1600000743
   b. FBI ORI #: MD920522Z
   c. Indicate the reason for fingerprinting: Professional License
   d. The type of check: Governmental licensing/certification

4. **Note:** After having your fingerprints taken, please retain your payment receipt in your records. You will need it to enter your CHRC receipt/confirmation number at the beginning of the Board's application for licensure, reinstatement, or registration. You may also use the barcode numbers on the fingerprint cards or your background check results letter from CJIS.

5. Pay all processing fees to the fingerprinting servicer or mail the fingerprint card and processing fee to CJIS. Do not mail your fingerprint card to the Board.

6. Download and print the **FBI Privacy Act Statement/Noncriminal Justice Applicant's Privacy Rights notice**. *You must acknowledge receipt of this notice when you file your application with the Board.* Please retain a copy in your files for future reference.

For additional information, please refer to the Frequently Asked Questions on the Board's website. If you have further questions about applying for a background check, please contact CJIS at 410-764-4501, or cjis.customerservice@maryland.gov.

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland
410-764-4777
www.mbp.state.md.us

Use this application *only* if you have never been licensed in Maryland as a Polysomnographic Technologist.

Attention Maryland licensed respiratory care practitioners: If you were licensed to practice respiratory care by the Board of Physicians on or before December 31, 2012 and if your duties included practicing polysomnography, you are not required to have a license to practice polysomnography in Maryland.

Dear Applicant:

Attached is an application packet for licensure as a Polysomnographic Technologist in Maryland. The licensure fee is **$200.00** and is **non-refundable.** Please make your check or money order payable to: **Maryland Board of Physicians.**
Mail your application and payment to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FedEx) and UPS do not deliver to post office boxes.**

Applications are processed in the order they are received. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Board staff will contact you if additional documentation is required. Please make sure your contact information is current. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school and verification of other licenses must come from the state board that issued your license. The Board will verify the Registered Polysomnographic Technologist (RPSGT) credential on the Board of Registered Polysomnographic Technologists (BRPT's) Website. In the event that it cannot be verified online, Board staff will require the Applicant to have the BRPT send written verification to the Board. **Effective November 30, 2016, the Board is accepting passage of the Sleep Disorder Specialty Examination administered by the National Board for Respiratory Care and the CRT-SDS and RRT-SDS certifications.** The same process for verification of education and credentials applies.

Board staff will not disclose the status of your application to another party unless you have completed the optional Third Party Release on Page 8 of the application. Please complete the third party release if you want your application disclosed to family members, friends, and future employers, etc.

The Board reviews applications in order of receipt. If your application **is missing information**, you will be contacted by **email** within 10-15 days. The email will list the information that is required to complete your application. You have 60 days to submit the required information. If you do not submit the required information within 60 days of the date of the email, your application will be closed, and a new application and a fee will be required.

The Board's Website is updated every 24 hours. You may wish to check the Website at *www.mbp.state.md.us* before calling the Board to learn if a license was issued to you. When you visit the Website, click on **Look up a Licensee**.

We look forward to receiving your completed application and will process it as quickly as possible.

Thank you,
The Allied Health Division
Maryland Board of Physicians

NOTICE FOR POLYSOMNOGRAPHIC TECHNOLGISTS

Graduation from a CAAHEP-accredited program or the A-STEP* is a requirement for licensure.

Applicants who graduated from the A-STEP also must have completed a clinical component (See supplemental form PSGT 4B) of an education program as established by the Polysomnography Professional Standards Committee and approved by the Board of Physicians.

NOTICE FOR RESPIRATORY THERAPISTS

Effective November 30, 2016, the Board is accepting the NBRC's Sleep Disorder Specialty credential (CRT-SDS and RRT-SDS) as one of the qualifications for licensure.

To qualify to use this credential, respiratory therapists are required to have graduated from a respiratory therapy program that includes the polysomnography add-on track.

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217
Baltimore, Maryland 21297
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION

The application should be completed *only* by individuals who have never been licensed in Maryland as a Polysomnographic Technologist.

1. **Name:** If the name on the application form differs from the name on your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order authorizing the name change. The Board of Physicians (the Board) must be notified of any change in your name on a timely basis.

2. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. This address is confidential. Do not use your practice address. **If you change your address prior to being licensed, immediately notify the Board in writing.**

3. **Public Address:** The public (business) address is your address of record, available to the public, and will be posted on your Practitioner Profile on the Board's Website. **If you change your address prior to being licensed, immediately notify the Board in writing.**

4. **Contact Information:** The Board will contact you using the information provided.

5. **Date of Birth:** Health Occupations Article (Health Occ.) §14-5C-09(b)(2), Annotated Code of Maryland, requires applicants to be at least 18 years old. Date of birth also will be used for identification and criminal background checks.

6. **Gender:** Disclosure of gender is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity:** Disclosure of race and ethnicity is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Board is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occ. §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid [42 U.S.C. §1396a(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320a-7].

9. **Employment Activities:** Please complete and include all employment history beginning with the date you graduated from high school.

POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

10. Verification of Education: Complete the appropriate box, then complete the top portion of the appropriate Verification of Education form and forward it to the American Academy of Sleep Medicine (AASM)/ Commission on Accreditation of Allied Health Education Programs (CAAHEP)-accredited program from which you graduated. Applicants must provide documentation for **one of the following four** pathways to licensure:

1. Graduation from a CAHEEP-accredited polysomnographic educational program;
2. Graduation from a CAAHEP-accredited respiratory care educational program and completion of a CAAHEP-accredited polysomnography add-on track;
3. Graduation from a CAAHEP-accredited electroneurodiagnostic technology educational program and completion of a CAAHEP-accredited polysomnography add-on track; or
4. Meet each of the following:
   a. Graduation from a sleep technologist educational program accredited by the AASM;
   b. Core competencies listed on the forms provided on the American Association of Sleep Technologist Core Competency Website (*http://www.aastweb.org/CoreCompetencies.aspx). Core competencies must be met in the three (3) years preceding the application and assessed by a credentialed RPSGT or a physician who is either board-eligible or board-certified in sleep medicine by the American Board of Sleep Medicine (ABSM), the American Board of Medical Specialties (ABMS), or the American Osteopathic Association (AOA);*
   c. A letter of attestation for completion of clinical hours and competencies from a physician who is either board-eligible or board-certified in sleep medicine by the ABSM, the ABMS, or the AOA; and
   d. Proof of completion of a minimum of 546 hours of clinical experience in the three (3) years preceding licensure application as either:
      i. A student supervised by a sleep technologist credentialed as an RPSGT at an AASM-accredited sleep laboratory or sleep laboratory accredited by The Joint Commission;

      Student is defined as an individual who is: (1) Enrolled in an accredited educational program in order to qualify for a license under this title; and (2) Performing polysomnography services within the accredited program under the supervision of a licensed physician and without compensation. Health Occ. §14-5C-01(h).

      OR

      ii. A sleep technologist with a current, active, unrestricted license in another state or is otherwise recognized and has practiced as a sleep technologist in another state who has:
         > Full-time practice experience as a sleep technologist in another state at an AASM-accredited sleep laboratory or sleep laboratory accredited by the Joint Commission for a minimum of six (6) months in the three (3) years preceding the application; and
         > Maintained an average of ten (10) continuing education units per year for the last two (2) years.

11. Oral and Written Competency in English: Demonstrate verbal and written competency in the English language by documentation of any of the following:

   a. Graduation from an English-speaking high school or undergraduate school after at least three (3) years of enrollment;
   b. Graduation from an English-speaking professional school; or
   c. Achievement of a passing score of at least 26 on the spoken part **and** 79 on the written part of the Test of English as a Foreign Language (TOEFL).

To take the test or obtain score reports for the TOEFL, contact the Educational Testing Services at *http://www.ets.org/toefl/contact/region1*. You will be asked to provide a PDF copy of your score report.

POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

12. **National Certification:** Please provide a copy of your **RPSGT** credential from the BRPT. Board staff will verify the credential on the BRPT's Website. In the event that Board staff cannot obtain verification, the Applicant will be asked to contact the BPRT and request that verification of certification be sent directly to the Board at P.O. Box 2571, Baltimore, MD 21215. Contact the BRPT at 703-610-9020 or go to its Website at *www.brpt.org*.

    The Board also accepts the CRT-SDS and RRT-SDS credentials for respiratory therapists who have passed the Sleep Disorders Specialty Examination administered by the National Board for Respiratory Care (NBRC) and graduated from a respiratory therapy program with a polysomnography add-on track. Board staff will verify the credential on the NBRC's Website. In the event that Board staff cannot obtain verification, the Applicant will be asked to contact the NBRC and request that verification of certification be sent directly to the Board. Contact the NBRC at 888-341-4811 or go to its Website at *www.nbrc.org*.

13. **Licensure in Other States:** If you have ever held a license, certification, or registration to practice polysomnography in any state or jurisdiction OR a license, certification, or registration to practice ANY other health care profession in any other state(s), including Maryland, complete the top portion of the Verification of Other State Licenses form (PSGT 5) and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form.

14. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were dishonorably discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD 214. Failure to provide a detailed explanation of a "YES" response and the required supporting documentation will delay the application process.

15. **Release:** Sign and date the certification. You are giving the Board and the Polysomnographic Professional Standards Committee permission to request additional information to support your application for licensure.

16. **Optional Third Party Release:** If you wish the Board to disclose the status of your application to a third party, complete the third party release statement.

17. **Cooperation in an Investigation:** You are expected to cooperate fully with any request for information related to your polysomnographic technologist application for licensure.

18. **Certification and Passport Quality Photo:** Sign and date the certification in the presence of a notary public after you have affixed a recent original passport quality (2" x 2") photo to the application in the space provided.

Please keep a copy of your application.

POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION FOR LICENSURE

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

Licensure and Renewal: If your application is approved, you will receive a license and an approval letter. The approval letter contains the license number assigned to you, the effective date of the license, and the date the license expires. Regardless of the date of initial licensure, your license will expire on May 30th of the first odd year following the date on which you are initially licensed, and you will have to renew your license if you plan to continue practicing in Maryland. The renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the current address on file. **You will be required to renew your license by May 30th of the first odd year whether or not you receive the renewal notice.**

PRACTICING POLYSOMNOGRAPHY: A person may not practice, attempt to practice, or offer to practice polysomnography in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides respiratory care unless the person is licensed to practice by the Board. Individuals practicing without a license may be fined up to $5,000.

The Maryland Board of Physicians supports the Americans with Disabilities Act (ADA) and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board's ADA designee, Rhonda Anderson, at (410) 764-5972 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Anderson.

BOARD OF PHYSICIANS
Maryland Department of Health

Name of Profession: _____

Check One:
- ☐ Initial Licensure
- ☐ Reinstatement

ATTENTION: Service Members, Veterans or Military Spouses

PLEASE REVIEW BEFORE PROCEEDING

The Board offers expedited licensure for service members, veterans, and military spouses. If a service member, veteran, or military spouse meets the requirements for licensure, the Board will issue the license within 15 days after receiving a completed application and fee.

✓	**"Veteran"** means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.
✗	**"Veteran"** does ***not*** include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.

"Military Spouse" means the spouse of a service member or veteran,

"Military Spouse" includes a surviving spouse of:
- ✓ A veteran; or
- ✓ A service member who died within one year before the date on which the application for license, certification, or registration is submitted.

"Service Member" means an individual who is an active duty member of:
- ✓ The Armed Forces of the U.S.A
- ✓ A reserve Component of the Armed Forces of the U.S.A; or
- ✓ The National Guards of any State

Complete ONLY if You Meet the Following Criteria

Check the appropriate box

- ☐ **Service Member** — Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any State. ***Provide a copy of your current military ID card.***
- ☐ **Veteran** — Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. ***Provide a copy of your DD214.***
- ☐ **Military Spouse**:
  - ☐ Spouse is a Veteran. ***Provide a copy of your spouse's DD214 and your marriage certificate.***
  - ☐ Spouse was a Service Member who died within one year before the date of submitting the application. ***Provide Uniformed Services ID Card DD2765.***
  - ☐ Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any State. ***Provide a copy of your spouse's current military ID and your marriage certificate.***

Name of Applicant: _____ Military Branch: _____

POLYSOMNOGRAPHY
INITIAL LICENSE
APPLICATION
11/2024

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 or Toll Free: 800-492-6836

POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION FOR LICENSURE

FOR BANK USE ONLY
Date: _____
Check Number: _____
Amount Paid: _____
Name Code: _____
App ID: 54
Fees: $200

Please print legibly or type the required information. Do not leave any item unanswered.

1. Your Complete Current Legal Name: As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): Complete name you would like to appear on your License.

First name and middle name:

(If applicable, please check a box and complete below) ☐Complete Maiden Name OR ☐Complete Former Name ☐Completed Legal Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. Non-Public Address: The non-public (home) address will be the location to which the Board directs all correspondence. This address is confidential.
Do not use your practice address.
Street Address: **(Do NOT use a P.O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

City | State | Zip Code

3. Public Address: The public (business) address is your address of record, available to the public, and will be posted on your Practitioner Profile on the Board's Website.
Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**

City | State | Zip Code

4. Telephone(s): Home | Office:

Cell/Pager: | E-mail Address:

5. Date of Birth: Month Day Year

6. Gender: ◯ Male ◯ Female

7. Race: Multiracial applicants may select all applicable categories ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

8. U.S. Social Security Number:

For Board Use Only	License Number:		Expiration Date:	
	Date Issued:			
	Licensed By: _____			

Print
Your
Name: ______________________________ Date: ______________

9. **Chronology of Employment Activities: Beginning with the date you graduated from high school and continuing through the present, list chronologically all of your employment activities. Explain any lapse in time over one (1) year in which you were not employed. Include non-health related employment history.**

Graduation Date from High School:

Employment activities after high school graduation:

month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**
month	year		month	year	**Activity/Position:**
		TO			
Name and telephone of Supervisor:					**Name and Address of Employer:**

If you will need more space than this page allows, please photocopy this page for your use. Please sign and date each sheet you attach.

10. EDUCATION: COMPLETE THE APPROPRIATE EDUCATIONAL PROGRAM LISTED ON PAGE 3 OR 4.

a. **Polysomnography educational program**. Complete this section and the attached **Verification of Education form (PSGT 1)** and forward to the school or program from which you graduated.

_____ _____/_____/_____
Name of Polysomnography Program Graduation Date

_____
Address

_____
City State Zip Code

b. **Respiratory care educational program which included a polysomnography add-on track**. Complete this section and the attached **Verification of Education form (PSGT 2)** and forward to the school or program from which you graduated. ***If you were licensed to practice respiratory care by the Board on or before December 31, 2012 and if your duties included practicing polysomnography, you are not required to have a license to practice polysomnography in Maryland.***

_____ _____/_____/_____
Name of Respiratory Care Program Graduation Date

_____
Address

_____
City State Zip Code

c. **Electroneurodiagnostic educational program which included a polysomnography add-on track**. Complete the attached **Verification of Education form (PSGT 3)** and forward to the school or program from which you graduated.

_____ _____/_____/_____
Name of Electroneurodiagnostic Program Graduation Date

_____
Address

_____
City State Zip Code

EDUCATION (continued): COMPLETE THE APPROPRIATE EDUCATIONAL PROGRAM

d1. **Accredited Sleep Technology Program (A-STEP).** Complete this section and the attached **Verification of Education form (PSGT 4A)** and forward to the school or program from which you graduated.

_____ _____/_____/_____
Name of A-STEP Provider Completion Date

_____
Address

_____
City State Zip Code

d2. **In addition to completing the A-STEP program, applicants must also:**

- Document meeting core competencies within the three (3) years preceding the application as assessed by an RPSGT, or a physician who is either Board-eligible or Board-certified in sleep medicine by the American Board of Medical Specialties (ABMS), the American Board of Sleep Medicine (ABSM), or the American Osteopathic Association (AOA). *Documentation of clinical competency should be on forms obtained from the American Association of Sleep Technologists (AAST) Core Competency Website: www.aastweb.org/core-competencies.*

  Please submit the following completed competency forms:

  * Polysomnography
  * Scoring Sleep Stages and Clinical Events in Polysomnographic Technology
  * Pap Titration in Sleep Technology
  * Supplemental Low Flow Oxygen and Titration
  * Monitoring Pulse Oximetry
  * Maintenance, Cleaning and Safety Precautions in Polysomnography Technology

- Submit a letter of attestation for completion of clinical hours and competencies from a physician who is either Board-eligible or Board certified in sleep medicine by the ABMS or the ABSM. [Please complete the attached **Attestation of Clinical Hours and Core Competencies form (PSGT 4B)].**

- Provide proof of completion of at least 546 hours of clinical experience within the last three (3) years immediately preceding the submission of the application as either:

  ◊ A student supervised by an RPSGTat an AASM-accredited sleep lab or a sleep lab accredited by The Joint Commission; ***Student is defined as an individual who is: (1) Enrolled in an accredited educational program in order to qualify for a license under this title; and (2) Performing polysomnography services within the accredited program under the supervision of a licensed physician and without compensation. Health Occ. §14-5C-01(h).***

  OR

  ◊ A sleep technologist with a current, active, unrestricted license in another state or is otherwise recognized and has practiced as a sleep technologist in another state with full-time practice experience in an AASM-accredited sleep lab or sleep lab accredited by The Joint Commission for minimum of six (6) months in the three (3) years preceding the application and has maintained an average of ten (10) continuing education units per year for the last two (2) years.

11. ORAL AND WRITTEN COMPETENCY IN ENGLISH (CHECK ONE)

☐ I graduated from an English-speaking high school or undergraduate school after at least three (3) years of enrollment;*

Name of high school: _____

City and state of high school: _____

** Please provide a copy of your high school and/or undergraduate school transcript.*

☐ I graduated from an English-speaking professional school; or

☐ I achieved a passing score of at least 26 on the spoken part of the TOEFL **and** 79 on the written part of the TOEFL.**

*** Please attach a PDF copy of your score report to the application.*

12. **NATIONAL CERTIFICATION**: Include a copy of your credential with your application. Board staff will verify the credential on the credentialing agency's Website. In the event that Board staff cannot obtain verification, the Applicant will be asked to contact the agency and have verification of your certifying credential sent to the Board.

Exam/Credential	Date of Certification	Certification #
BRPT-RPSGT	_____/_____/_____	_____
CRT-SDS or RRT-SDS *(circle one)*	_____/_____/_____	_____

13a. Licensure as a Polysomnographic Technologist. List all states or other jurisdictions in which you ever held a license to practice polysomnography. Please complete and mail the attached **Verification of Other State Licenses** form to the appropriate state board(s). If you have never been licensed as a polysomnographic technologist, write **N/A** here _____.

State	License #	Credential	Year Issued	Expiration Date

13b. Licensure as another health care practitioner. List all states or other jurisdictions in which you ever held a license to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State Licenses** form to the appropriate state board(s). If you have never been licensed as any other health care professional, write **N/A** here _____.

State	License #	Category (RN, CRT/RRT, PA)	Year Issued	Expiration Date

14. Character and Fitness Questions (Check either **YES** or **NO) Please answer questions "a" through "q" on pages 6 and 7.**

	YES	NO	
a.	◯	◯	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, denied your application for licensure, reinstatement, or renewal?
b.	◯	◯	Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.
c.	◯	◯	Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, filed any complaints or charges against you or investigated you for any reason?
d.	◯	◯	Have you withdrawn your application for a medical license or other health professional license?
e.	◯	◯	Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
f.	◯	◯	Has a hospital, related health care institution, HMO, or alternative health care system denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?
g.	◯	◯	Have you ever pleaded guilty or *nolo contendere* (no contest) to any criminal charge, regardless of whether adjudication was withheld, or have been convicted of a crime or placed on probation before judgment because of a criminal charge?
h.	◯	◯	Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere* (no contest), regardless of whether adjudication was withheld, or for which you were convicted or received probation before judgment?
i.	◯	◯	Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?
j.	◯	◯	Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

Important: The Board recognizes that licensees encounter health conditions, including those involving career fatigue, burnout, mental health, and substance use disorders, just as their patients and other healthcare providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Voluntary options may include seeking medical care, self-limiting the licensee's practice, or voluntarily self-referring to the Maryland Healthcare Professionals Program (MHPP) a program that provides assistance to healthcare professionals dealing with potentially impairing conditions in a private, non-disciplinary setting while protecting both the confidentiality of the participant and the safety of the public.

If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents.
Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

Continue to Page 7 for questions "k" through "q"

14a. Character and Fitness Questions Continued (Check either YES or NO)

	YES	NO	
k.	◯	◯	Have any malpractice claims or other claims for money damages been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.
l.	◯	◯	Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education?
m.	◯	◯	Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
n.	◯	◯	Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration been terminated for disciplinary reasons?
o.	◯	◯	Have you voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?
p.	◯	◯	Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?
q.	◯	◯	Have you been dishonorably discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

»»» **If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.**

RELEASE AND CERTIFICATION

15. Release:

I agree that the Maryland Board of Physicians (the Board) and the Polysomnography Professional Standards Committee may request any information necessary to process my application for licensure as a polysomnographic technologist in Maryland from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Applicant's Name (Printed) _____ Applicant's Signature _____ Date _____

16. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____ Applicant's Signature _____ Date _____

17. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my polysomnograhic technologist application for licensure, including the subpoena of documents and/or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address, or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-5C-17.

Applicant's Signature _____ Date _____

18. Certification: To be completed by the Applicant in the presence of a notary public after the Applicant's picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (Md. Code Ann., Health Occ. 14-5C-01 *et seq*.) and Code of Maryland Regulations (COMAR) 10.32.06 *et seq.* which govern the practice of Polysomnographic Technologists in Maryland.

Applicant's Signature _____ Date _____

STATE OF _____

CITY/COUNTY OF _____

I HEREBY CERTIFY that on this _____ day of _____ , 20_____ , before me, a Notary Public of the State and

City/County aforesaid, personally appeared the Applicant, _____ , whose likeness is identifiable as that of
(print applicant's name)

the individual in the photograph attached to this application and who has made oath in due form of law that signing the foregoing application was his voluntary act and deed.

AS WITNESS my hand and notorial seal. _____
Notary Public

My Commission expires: _____

SEAL

APPLICANT:

PASTE YOUR PASSPORT-QUALITY PHOTO HERE BEFORE NOTARIZING

COPIES OF PHOTOS ARE NOT ACCEPTABLE

STOP! Completed application and payment of $200 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION FOR LICENSURE

Supplemental Forms

PSGT 1—Verification of Education from an accredited PSG program

PSGT 2—Verification of Education from a respiratory therapy program with the PSG add-on track

PSGT 3—Verification of Education from an electroneurodiagnostic technology program with a PSG add-on track

PSGT 4A / 4B—Verification of A-STEP and attestation of clinical hours and core competencies

PSGT 5—Verification of Other State Licenses

Verification of Education: Polysomnography

PSGT 1 (11/2024)

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ _____
Y N
Date verified: _____

VERIFICATION OF EDUCATION OF POLYSOMNOGRAPHY PROGRAM FOR POLYSOMNOGRAPHIC TECHNOLOGIST LICENSURE

Part 1

APPLICANT: Complete Part 1 and send this form to the institution where you completed your Polysomnography program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden name

Date of Birth: _____/_____/_____ Social Secuity Number: _____ - _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please email this form to: mdh.mbpcredentials@maryland.gov

I hereby certify that the above-named individual attended this institution during the inclusive dates of:

_____ to _____. The individual graduated with a(n):
mm/dd/yyyy mm/dd/yyyy

☐ A.S./A.S. ☐ Certificate ☐ B.S./B.A. ☐ Master's Degree ☐ Other: _____ (specify)

in _____ on _____.
Educational Program mm/dd/yyyy

The program was accredited by: _____.
Name of accrediting agency, e.g., CAAHEP

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION

Verification of Education:
RT with PSG add-on track

PSGT 2 (11/2024)

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ Y _____ N
Date verified: _____

VERIFICATION OF EDUCATION OF RESPIRATORY THERAPY PROGRAM WITH ADD-ON TRACK FOR POLYSOMNOGRAPHIC TECHNOLOGIST LICENSURE

Part 1

APPLICANT: Complete Part 1 and send this form to the institution where you completed your Respiratory Therapy program with add-on track.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden name

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates of:

_____ to _____. The individual graduated with a(n):
mm/dd/yyyy mm/dd/yyyy

☐ A.S./A.S. ☐ Certificate ☐ B.S./B.A. ☐ Master's Degree ☐ Other: _____ (specify)

in _____ on _____.
Educational Program mm/dd/yyyy

The program was accredited by: _____.
Name of accrediting agency, e.g., CAAHEP

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION

Verification of Education:
ENT with PSG add-on track

PSGT 3 (11/2024)

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ Y _____ N
Date verified: _____

VERIFICATION OF EDUCATION OF ELECTRONEURODIAGNOSTIC PROGRAM WITH ADD-ON TRACK FOR POLYSOMNOGRAPHIC TECHNOLOGIST LICENSURE

Part 1

APPLICANT: Complete Part 1 and send this form to the institution where you completed your Electroneurodiagnostic program with add-on track.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden name

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates of:

_____ to _____. The individual graduated with a(n):
mm/dd/yyyy mm/dd/yyyy

☐ A.S./A.S. ☐ Certificate ☐ B.S./B.A. ☐ Master's Degree ☐ Other: _____ (specify)

in _____ on _____.
Educational Program mm/dd/yyyy

The program was accredited by: _____.
Name of accrediting agency, e.g., CAAHEP

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION

Verification of Education: A-STEP with Clinical Component PSGT 4A (11/2024)

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ Y _____ N
Date verified: _____

VERIFICATION OF EDUCATION: ACCREDITED SLEEP TECHNOLOGIST EDUCATION PROGRAM

Part 1

APPLICANT: Complete Part 1 and send this form to the provider where you completed your A-STEP.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden name

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____
mm dd yyyy

A-STEP Provider: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates of:

_____ to _____. The individual graduated with a(n):
mm/dd/yyyy mm/dd/yyyy

☐ A.S./A.S. ☐ Certificate ☐ B.S./B.A. ☐ Master's Degree ☐ Other: _____ (specify)

in _____ on _____.
Educational Program mm/dd/yyyy

The program was accredited by: _____.
Name of accrediting agency, e.g., CAAHEP, AASM

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION

Attestation: Clinical Hours and Core Competencies
PSGT 4B
(11/2024)

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ _____
Y N
Date verified: _____

ATTESTATION OF COMPLETION OF CLINICAL HOURS AND CORE COMPETENCIES

Part 1 APPLICANT: Complete Part 1 and then send this form to your supervisor.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden name

Address: _____

PLEASE READ CAREFULLY AND INITIAL EACH APPLICABLE STATEMENT AND THEN SIGN AND DATE BELOW

_____ I attest that I have successfully completed 546 hours of clinical competencies within the three (3) years preceding this application as a student at an AASM or Joint Commission-accredited sleep laboratory. *(Lab accreditation number _____)*
Student is defined as an individual who is: (1) Enrolled in an accredited educational program in order to qualify for a license under this title; and (2) Performing polysomnography services within the accredited program under the supervision of a licensed physician and without compensation. Health Occ. §14-5C-01(h).

_____ I attest that I have maintained an average of ten (10) continuing education units per year for the last two (2) years.
Out of state only *(Attach documentation of completed continuing education)*

_____ _____
Signature of Applicant Date

Part 2 SLEEP TECHNOLOGIST OR SLEEP MEDICINE PHYSICIAN PERFORMING ASSESSMENT OF CORE COMPETENCIES: Complete Part 2.

I attest that _____ has completed core competencies in my presence at an AASM or a Joint
Printed Name of Applicant
Commission-accredited sleep laboratory within the past three (3) years preceding this application. The applicant completed the core competencies from _____ to _____.
Month, Year Month, Year

I also attest that I am a (check one):

☐ Sleep Technologist credentialed RPSGT (RPSGT Certification # _____)

☐ BE or BC in Sleep Medicine (ABSM/ABMS/AOA Certification # _____)

_____ _____ _____
Name of Individual Completing Assessment License Number AASM or Joint Commission Accreditation Number

_____ _____
Signature of Individual Completing Assessment Date

Part 3 PHYSICIAN BOARD ELIGIBLE OR BOARD CERTIFIED IN SLEEP MEDICINE: Complete Part 3.

I, _____, am a Board Certified or Board Eligible Sleep Specialist, and I hereby certify that I have personal
Printed Name of Physician
knowledge that this candidate has completed the clinical experience and core competencies as indicated above. The 546 clinical hours were obtained from _____ to _____.
Month, Year Month, Year

If Board eligible, what year did you complete your postgraduate education? _____ *(Physicians are Board-eligible up to 7 years following successful completion of accredited training, plus time (if any) in practice as required by the board for admissibility to the certifying exam.)*

If Board certified, please list the board and your certification number _____ _____
Board name Certification Number

_____ _____ _____
Signature of Physician Date Degree / State and License Number

Verification of Other State Licenses

PSGT 5 (11/2024)

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

VERIFICATION OF OTHER STATE LICENSES

Part 1

APPLICANT: Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license to practice as a Polysomnography. Also use this form to send to each state board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: _____

State of Licensure: _____ License Number: _____

Date: _____ Expiration Date: _____

Name: _____
(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : _____ Date of Birth: _____/_____/_____

Professional School of Graduation: _____ Year: _____

Signature: _____ Date: _____

Part 2

AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD: Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

_____ _____ _____
License Number Date Issued Expiration Date

Is/was the license in good standing? ☐ **Yes** ☐ **No**

If not in good standing is/was it: ☐ **reprimanded** ☐ **suspended** ☐ **revoked** ☐ **surrendered**

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? ◯ **Yes** ◯ **No**

If yes, please explain: _____

_____

Other Derogatory Information or Pending Charges: _____

_____

_____ _____
Printed Name of Authorized Official Direct Telephone Number

_____ _____
Title of Authorized Official Printed Name of State

_____ _____
Signature of Authorized Official Date

State Board Seal