MARYLAND BOARD OF PHYSICIANS

P. O. BOX 37217
BALTIMORE MARYLAND 21297
(410)764-4777
1-800-492-6836
www.mbp.state.md.us

TTY FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258

APPLICATION FOR LICENSURE OF POLYSOMNOGRAPHIC TECHNOLOGISTS

INSTRUCTIONS AND IMPORTANT INFORMATION

1. **Fee:** The fee for licensure as a Polysomnographic Technologist is **$200.00**. Checks and/or money orders should be made payable to the Maryland Board of Physicians. **The application fee is not refundable. (Please note that without the required fee, your application will not be processed.)**

2. **Mailing Instructions:** Mail your completed application, appropriate fee and supporting documentation to **P.O. Box 37217, Baltimore, MD 21297**, the address at the top of this page. DO NOT mail or hand deliver your application to the Board office. Any application that is mailed or hand delivered to the Board office will be forwarded to the post office box at the top of the application. This will delay the processing of your application. **PLEASE NOTE: Federal Express (FEDEX) or UPS does not deliver to post office boxes.**

3. **Processing time:** Generally, the application process takes 2 - 4 weeks. However, the process may take longer depending on the individual applicant's circumstances or if the individual does not provide the required documentation on a timely basis.

Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will mail a letter to you requesting additional documentation if additional documentation is required.

If you have met all the requirements for licensure, your analyst will generally issue a license within 3-5 business days from the receipt of your application. Once the license is issued, you should be able to check it on the Board's website at *www.mbp.state.md.us. The website is updated every 24 hours.*

PRIOR TO CONTACTING YOUR ANALYST, PLEASE CHECK THE BOARD'S WEBSITE TO DETERMINE IF YOU HAVE BEEN ISSUED A LICENSE. Click Search Practitioner Profiles, then enter your last name into the appropriate field.

4. **Application:** Complete all questions on the application. 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 discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge. Incomplete applications will delay the review process.**

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

5. **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 explaining the change of name. The Board must be notified of any change in your name on a timely basis.

INSTRUCTIONS AND IMPORTANT INFORMATION (Continued)

6. **Address**: The non-public (home) address will be the location to which the Board directs all correspondence. The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

7. **Race and Sex**: Race and gender are not requirements of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

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

9. **Social Security Number**: Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians 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 Occupations Article, §1-210);
D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).

10. **Verification of Education:** Complete the top portion of one the Verification of Professional Education forms and **forward it to the CAAHEP-accredited program from which you graduated**.

11. **National Certification**: Please provide a copy of your RPSGT credential from the Board for Registered Polysomnographic Technologists (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 ask them to send verification of certification directly to the Board's office at 4201 Patterson, Baltimore, MD 21215. ***(Please DO NOT send applications to is address.)*** Contact the BRPT at 703-610-9020 or go to their website at ***www.brpt.org.***

12**. 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 in ANY other health care profession in any other state(s), including Maryland, complete the top portion of the **Verification of Other State Licenses form 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.**

13. **English Language Competency:** Demonstrate verbal and written competency in the English language by:

a. Graduation from an English-speaking high school, undergraduate school, or professional school; **OR**

Provide evidence that you achieved a passing score on both the Test of Spoken English (TSE) and the Test of English as Foreign Language (TOEFL).

b. Achieve a passing score of at least 220 on the TSE **and** at least 550 TOEFL Paper and Pencil examination taken before July 1995; **OR**
c. Achieve a passing score of at least 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam beginning July 1995; **OR**
d. Achieve a passing score of at least 26 on the spoken part **and** 79 on the written part of the TOEFL.

To obtain score reports for the the TSE and the TOEFL, contact the Educational Testing Services by phone at 1-877-863-3546 or 609-771-7100; by fax 610-290-8922; or on their website at www.ets.org.

INSTRUCTIONS AND IMPORTANT INFORMATION (Continued)

14**. Release and Certification:** A recent photograph must be pasted to the release and the form must be signed and dated in the presence of a notary. If you wish the Board to release your information to a third party, complete the third party release statement. Sign and date the certification. Your application will not be processed if the Release and Certification are not signed and dated.

15. **Licensure and Renewal:** If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, a license and wall certificate. Regardless of the date of initial licensure, your license will expire on May 30th of the first even 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 30 of the first even 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 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 ADA designee, Ellen Douglas Smith at (410)764-4777 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. Smith.

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FOR BANK USE ONLY
DATE:______/______/ 200___
CHECK NUMBER:____________
AMT PAID: $ _______________
NAME CODE:_______________
APPID: 54

FOR BOARD USE ONLY
LICENSE NUMBER __________________
DATE LICENSED _____/______/_______
EXPIRATION DATE _____/_____/______

APPLICATION FOR LICENSURE

POLYSOMNOGRAPHIC TECHNOLOGISTS

Fee: $200.00

TYPE OR PRINT LEGIBLY

1. **Full Legal Name:**

____
Last Name and Generational Indicator (Jr., III, etc.)

____
First Name **Middle Initial** **Maiden Name**

2a. **Non-public Address:** (Do Not use a P.O. Box. This address, usually your home, is for correspondence between you and the Board. However, if no public address is listed, this address will be made available to the public. If you change your address prior to being **licensed**, immediately notify the Board in writing.)

____
Street Number and Name **Apt.**

____
City **State** **Zip code**

2b. Public Address: (Your public address, is your address of record. This address, usually your business address, is available to the public and may be posted on the internet. If you change your address prior to being **licensed**, immediately notify the Board in writing.)

____
Facility Name

____
Street Number and Name **Suite Number or P.O. Box**

____
City **State** **Zip code**

3a. Telephone - Home: (_______)__________-_________ **3b**. Work: (______)___________-___________

4. Email address: ____

5. Social Security Number: _______-_________-_______ **6. Date of Birth:** ________/________/________
MM DD YYYY

7. Sex: _____ Male ____ Female **8. Ethinicity:** _____ Hispanic or Latino
_____ Not Hispanic or Latino

8a. Race: _____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ Native Hawaiian or Other Pacific Islander _____ White

Applicant's Name: _______________________________ Date:__________________

9. EDUCATION: SELECT AND COMPLETE THE APPROPRIATE EDUCATIONAL PROGRAM.
This requirement will become effective on October 1, 2011. Individuals applying for licensure before October 1, 2011 are not required to complete this page.

a. Polysomnography educational program. Complete the attached **Verification of Professional Education Form** 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 the attached **Verification of Professional Education Form** and forward to the school or program from which you graduated.

____ ________/________/________
Name of Respiratory Care Program **Graduation Date**

____
Address

____
City **State** **Zip code**

c. Electroneuro-diagnostic educational program which included a polysomnography add-on track. Complete the attached **Verification of Professional Education Form** and forward to the school or program from which you graduated.

____ ________/________/________
Name of Electroneuro-diagnostic Program **Graduation Date**

____
Address

____
City **State** **Zip code**

Applicant's Name: _______________________________ ***Date:__________________***

10. NATIONAL CERTIFICATION: Include a copy of your BRPT credential with your application. 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 ask them to send verification of your certification to the Board's office at 4201 Patterson, Baltimore, MD 21215. **(Please do not send your application to this address.)**

Date of Certification **Certification #**

______/_____/______ ____________________

11. ORAL AND COMPETENCY IN ENGLISH (CHECK ONE)

_____ I graduated from a recognized English-speaking professional school; **OR**

_____ I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment; **OR**

I achieved a passing score of at least:

______ 220 on the TSE **and** at least 550 TOEFL Paper and Pencil examination taken before July 1995; **OR**

______ 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam beginning July 1995; **OR**

______ 26 on the spoken part **and** 79 on the written part of the TOEFL.

12a. List all states or other jurisdictions in which you have ever held a license/certification/registration to practice polysomnography. Please complete and mail the attached **Verification of Other State License(s)** form to the appropriate state board(s). If you have never been licensed/certified/registered in any health occupation, **write N/A here ____________________________.**

STATE	REGISTRATION/LICENSE#	CATEGORY (RRT, R.N., Etc.)	YEAR ISSUED	EXPIRATION DATE

12b. List all states or other jurisdictions, including Maryland in which you have ever held a license/certification/registration to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s)** form to the appropriate state board(s). If you have never been licensed/certified/registered in any health occupation, **write N/A here ____________________________.**

STATE	REGISTRATION/LICENSE#	CATEGORY (RRT, R.N., Etc.)	YEAR ISSUED	EXPIRATION DATE

Applicant's Name: ______________________________ ***Date:***__________________

CHARACTER AND FITNESS QUESTIONS

13. Answer **YES"** or **"NO"** to the following items. If you answered **"YES"** to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Examples of documentation is next to the question. Please note that these examples are not all inclusive. ***Failure to provide documentation and a signed and dated explanation will delay the processing of your application.***

______ A. Have you ever been denied a license, certification or registration to practice any health occupation? **(e.g. state board orders and/or charges; adverse or disciplinary actions in any healthcare facility)**

______ B. Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? **(e.g. state board orders and/or charges; adverse or disciplinary actions)**

______ C. Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? **(e.g. state board orders and/or charges; adverse or disciplinary actions)**

______ D. Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? **(e.g. provide name of institution, correspondence received or sent, related documents.)**

______ E. Have you ever been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? **(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**

______ F. Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? **(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)**

______ G. Do you currently have a physical or mental condition which may affect your ability to practice your profession? **(e.g. medical evaluations)**

______ H. Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? **(e.g. malpractice claims)**

______ I. Have you ever been 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, type of discharge. **(e.g. DD214)**

______ J. Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? **(e.g. copy of charges)**

Applicant's Name: ______________________________ *Date:*_________________

POLYSOMNOGRAPHIC TECHNOLOGISTS

14. Beginning with the most recent, describe your employment history since graduation from high school. Explain any lapsed time over 1 year in which you were not employed. Please copy this page if more space is needed.

Length of Employment Month and Year	1) Name of Employer 2) Address of Employer 3) City, State, Zip Code 4) Supervisor	Position Phone Number
From	1)	
	2)	
	3)	
To	4)	
From	1)	
	2)	
	3)	
To	4)	
From	1)	
	2)	
	3)	
To	4)	
From	1)	
	2)	
	3)	
To	4)	

15. RELEASE:

I agree that the Maryland Board of Physicians (the Board) and **Polysomongraphy 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 Healthcare Integrity and Protection 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.

____

Name in print

____

Signature **Date**

AFFIX A PASSPORT QUALITY PHOTO TAKEN WITHIN 90 DAYS PRIOR TO SUBMITTING THE APPLICATION.

16. Affix a passport quality photo taken within the last 90 prior to submitting the application.

Date picture was taken

_________ __________ _________
mm dd yyyy

17. (Optional) Third Party Release: (If you plan to use an intermediary to receive information about the status of your application, please complete the 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 of person to whom the information can be released Date

____ ______________________
Phone number if person to whom information can be released Applicant's signature

18. CERTIFICATION: THE FOLLOWING MUST BE SIGNED AND DATED IN THE PRESENCE OF A NOTARY PUBLIC AFTER THE APPLICANT'S PICTURE HAS BEEN ATTACHED ABOVE. ***YOUR APPLICATION WILL NOT BE PROCESSED IF THE CERTIFICATION IS NOT SIGNED AND DATED.***

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 which govern the practice of Polysomnographic Technologists in Maryland.

_______________________________ _______________________
Applicant's Signature Date

19. NOTARY: PLEASE COMPLETE THEN AFFIX NOTARY SEAL.

STATE OF ______________________________ CITY/COUNTY OF ______________________________

I HEREBY CERTIFY that on this __________ day of __________, 200_____, before me, ______________________________,
(print name of notary)
a Notary Public of the aforesaid State and City/County, personally appeared ______________________________, and made oath in
(print name of applicant)

due form of law that signing the foregoing application was his voluntary act and deed. AS WITNESS my hand and Notarial Seal.

___________________________________ My Commission Expires: ______________________________
Notary Public

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VERIFICATION OF OTHER STATE LICENSE(S)
Polysomnographic Technologist

APPLICANT: Please complete and sign **Part 1** of this form and mail it to each state board that ever issued you a certification, license or registration to practice 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 allied health professional. Contact the state(s) to which you are sending this form to request fee information. Please copy this verification request if you need to send it to more than one state board.

PART1:

Name of State Board: ____________________

Location of State Board: ____________________
City State

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

Date of Birth: ____________ Social Security Number: ____________

Certification/license/registration number: ____________ Date issued: ________ Expiration Date: ________

Professional School of Graduation: ____________ Year: ________

Signature: ____________ Date: ____________

PART 2: TO BE COMPLETED BY STATE BOARD: Authorized Official: Please certify the following information for the above individual and send this form directly to the Maryland Board of Physicians at the above address.

Certification/license/registration number: ____________ Date issued: ________ Expiration Date: ________

Is license/certification/registration in good standing? ________ Not in good standing? ________

If not in good standing was it: revoked _______ suspended _______ surrendered _______ reprimanded ________

Other Derogatory Information or Pending Charges: ____________________

____

____

Printed Name of Authorized Official: ____________ Title: ____________

Signature of Authorized Official: ____________ Date: ____________

Telephone Number, including area code: ____________________

BOARD SEAL

NOTICE

Graduation from a CAAHEP-accredited program is a requirement for licensure. However, the requirement is waived until October 1, 2011.

Individuals applying for licensure before October 1, 2011 are not required to complete a Verification of Education form.

For Board Use Only

Program accredited? ____ ____
Y N

Date verified ___________

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VERIFICATION OF PROFESSIONAL EDUCATION OF POLYSOMNOGRAPHY PROGRAM FOR POLYSOMNOGRAPHIC TECHNOLOGIST LICENSURE

APPLICANT: Please complete **Part 1** and send to the institution where you completed the **Polysomnography** program.

PART 1:

Name:____

Last First Middle Maiden

Birth Date:______________________________ Social Security Number:______________________________

Professional School of Graduation: ____

Date of Graduation:______________________Degree Received:____________________________

Inclusive Dates of Attendance: From ______________________ To______________________

mm/yyyy mm/yyyy

__________________________________ ______________________

Signature of Applicant Date

****

Authorized Official: Please complete **Part 2** of this form and mail it directly to the Maryland Board of Physicians at the above address.

PART 2: I hereby certify that the above-named individual graduated from this school/program on: _________________.

Date of Graduation

The individual received a ______________________ in ________________________________. The inclusive

Type: Certificate, AS, AA,BS, BA, etc. Educational Program

dates of attendance were _________ to __________. The program was accredited by ________________________

MM/YYYY MM/YYYY Name of accreditor, e.g. CAAHEP

____

Name of School/Program (Please print)

____

Name of School Official (Print)

____

Signature of School Official Date

____

Title of School Official

SEAL OF EDUCATIONAL PROGRAM

____

Telephone Number (including area code)

12/2008

For Board Use Only

Program accredited? ____ ____
Y N

Date verified ___________

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

APPLICANT: Please complete **Part 1** and send to the institution where you completed the **Respiratory Therapy** program with **add-on track**.

PART 1:

Name:____

Last First Middle Maiden

Birth Date:______________________________ Social Security Number:______________________________

Professional School of Graduation: ____

Date of Graduation:______________________Degree Received:___________________________________

Inclusive Dates of Attendance: From ______________________ To________________________

mm/yyyy mm/yyyy

__________________________________ ______________________

Signature of Applicant Date

****

Authorized Official: Please complete **Part 2** of this form and mail it directly to the Maryland Board of Physicians at the above address.

PART 2: I hereby certify that the above-named individual graduated from this school/program on: ________________.

Date of Graduation

The individual received a ______________________ in _______________________________. The inclusive

Type: Certificate, AS, AA,BS, BA, etc. Educational Program

dates of attendance were ________ to _________. The program was accredited by _______________________

MM/YYYY MM/YYYY Name of accreditor, e.g. CAAHEP

____

Name of School/Program (Please print)

____

Name of School Official (Print)

____

Signature of School Official Date

____

Title of School Official

SEAL OF EDUCATIONAL PROGRAM

____

Telephone Number (including area code)

12/2008

For Board Use Only

Program accredited? ____ ____
Y N

Date verified ___________

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VERIFICATION OF PROFESSIONAL EDUCATION OF ELECTRONEURO-DIAGNOSTIC PROGRAM WITH ADD-ON TRACK FOR POLYSOMNOGRAPHIC TECHNOLOGIST LICENSURE

APPLICANT: Please complete **Part 1** and send to the institution where you completed the **Electroneuro-diagnostic** program with **add-on track**.

PART 1:

Name:____
Last First Middle Maiden

Birth Date:_________________________ Social Security Number:_________________________

Professional School of Graduation: ____

Date of Graduation:___________________Degree Received:______________________________

Inclusive Dates of Attendance: From ___________________ To___________________
mm/yyyy mm/yyyy

_____________________________ _____________________
Signature of Applicant Date

****

Authorized Official: Please complete **Part 2** of this form and mail it directly to the Maryland Board of Physicians at the above address.

PART 2: I hereby certify that the above-named individual graduated from this school/program on: _____________.
Date of Graduation

The individual received a ___________________ in ___________________________. The inclusive
Type: Certificate, AS, AA,BS, BA, etc. Educational Program

dates of attendance were _______ to ________. The program was accredited by ____________________
MM/YYYY MM/YYYY Name of accreditor, e.g. CAAHEP

____
Name of School/Program (Please print)

____
Name of School Official (Print)

____
Signature of School Official Date

____ **SEAL OF EDUCATIONAL PROGRAM**
Title of School Official

____
Telephone Number (including area code)

12/2008