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
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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