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

MARYLAND BOARD OF PHYSICIANS
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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