POLYSOMNOGRAPHY APPLICATION INSTRUCTIONS

FEES

- Application Fee: PSG - $100; Provisional Technician - $50
  - Mail application fee with application.
  - Payment can be by check, money order (payable to IDAHO STATE BOARD OF MEDICINE), or credit card (Credit Card Transmittal Form included)
- Application and all license fees are non-refundable.

APP1

- Check the box for either PSG Technologist or Provisional Technician *(has graduated but has not passed National Exam; expires 6 months from issue date and is not renewable).*
- Complete all sections.
- If Applicant has not applied for registration/licensure in other states, write "Not Applicable" in the appropriate section.

APP2

- Complete all sections.
- History cannot have any gap of more than one month. Attach additional sheets for history, if necessary.
- Answer all questions 1-8.
  - Provide details, for YES answers, on a separate sheet.
  - YES answers will require additional documentation (DD-214, court documents, etc.).
- Application must be signed by Applicant and notarized by a notary public.

The above items <u>cannot</u> be faxed or emailed.

The items listed below are to be requested by Applicant and <u>can</u> be faxed or emailed. FAX: 208-334-3536; Email: BOM-Licensing@dopl.idaho.gov

EDU1 (VERIFICATION OF PROFESSIONAL EDUCATION)

- Complete Applicant section only.
- Form must be signed by Applicant.
- Send this form to institution where Applicant completed their education in polysomnography related respiratory care.
  - Registrar/Program Director **<u>must</u>** return completed form **<u>directly</u>** to the Board of Medicine.

CPR CERTIFICATION

- Applicant must provide proof of current CPR certification *(photocopy of card is acceptable)*.

NATIONAL EXAM VERIFICATION

- Applicants for PSG must request verification from the BRPT.
  - BRPT Website: www.brpt.org
- Verification must be sent from the BRPT **<u>directly</u>** to the Board of Medicine.

VERIFICATION OF REGISTRATION/LICENSURE:

- Required from all states in which Applicant holds or has held licensure/registration.
- Verification must be sent from the state of licensure **<u>directly</u>** to the Board of Medicine.

PROV1 (SUPERVISOR AFFIDAVIT)

- Applicants that have not yet passed the BRPT exam and are applying for a **provisional** license must submit this form.
- Complete Applicant section only.
- Supervisor must be a currently licensed Idaho respiratory therapist or physician.
- Must be signed by Supervisor and notarized by a notary public.

AUTH1 (Authorization for Release of Information)

- Required to release information to individual(s) other than Applicant.
- Must be signed by Applicant and notarized by a notary public.

No practice is permitted prior to issuance of a permit number.
Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that licensure will be granted.
Incomplete applications are held for up to 1 year, after that, all documents will be destroyed.

State of Idaho
Division Of Occupational and Professional Licenses
Board of Medicine

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

CREDIT CARD TRANSMITTAL FORM

For security of your financial information, please do not email this form to the Board.

Please type or print legibly

Order Information: _____
(Description of what and who payment is for)

Name as it appears on card: _____

Billing Address: _____

City _____ State _____ Postal Code _____

Telephone Number: _____

Card Number: _____-_____-_____-_____

Type of Card ☐ MasterCard ☐ Visa

Expiration Date: _____ /_____
(MM) (YY)

I authorize the Idaho Board of Medicine to charge the above credit card for a one-time payment in the amount of $ _____ .

Printed Name: _____

Authorized Signature: _____

Please Note: The Board of Medicine does not retain your credit card information.

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0063 · (208) 327-7000
Express Mail: 11341 W Chinden Blvd, Bldg 4 · Boise, ID 83714

APPLICATION - POLYSOMNOGRAPHY RELATED RESPIRATORY CARE PERMIT

FOR USE OF THE BOARD					
EDU1	CPR	BRPT	VER	PROV1 *(Supervisor)*	Received
	NPDB	AUTH1			

☐ PSG Technologist - $100

☐ Provisional Technician *(has not passed National Exam)* - $50

Please note: should your permit be issued to you on or before **March 30**, you will be required to renew by June 30 of that year. If you do not receive a permit until after that date, you will not be required to renew until June of the following year.

Before completing, please read instructions.

First Name	**Middle Name**	**Last Name**
Current Mailing Address (*Street*)		**Telephone**
(*City, State, Zip*)		**Alt. Telephone**
Public Address (*Street*)		**Social Security No.**
(*City, State, Zip*)		**Date of Birth** (*Month/Day/Year*)
Email Address		**Sex:** Male ☐ Female ☐

NAME AND LOCATION *(CITY/STATE)* **OF SCHOOLS**	**FROM** *(Month/Year)*	**TO** *(Month/Year)*
College/University		
Polysomnography Program		

BRPT Registry Number: _____

LIST ALL LICENSURE/REGISTRATION IN STATES AND/OR COUNTRIES *(below)*	**Year**	**GRANTED**		**CURRENT**		**NUMBER**
		Yes	**No**	**Yes**	**No**	

In chronological order, account for all periods of time from completion of professional school to present **leaving no gap in time of more than one month.** Include post-graduate study, private practice, military service, etc. Attach additional pages if necessary.

FROM (Month/Year)	**TO** (Month/Year)	**NAME OF INSTITUTION OR PLACE OF PRACTICE**	**LOCATION** (City, State)

NOTE

Tape a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 2"x2" passport to 3"x4" in size.

DO NOT STAPLE PHOTO TO APPLICATION

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

Y	N	
☐	☐	1. Are you in active service in the U.S. Military, an honorably discharged U.S. Military veteran, or a spouse of either one? *(If so, please be prepared to provide additional documentation)*
☐	☐	2. Have you ever failed a licensing examination for a professional license/registration?
☐	☐	3. Have you ever had an application for a professional license/registration denied or refused?
☐	☐	4. Have you ever been investigated by any licensing board, hospital, healthcare organization, agency or professional association in connection with incompetency, practice act violations, unprofessional conduct or unethical conduct *(even if no action resulted from the investigation)*?
☐	☐	5. Have you ever been found in violation of performing procedures or practicing beyond the scope approved by a licensing or regulatory agency?
☐	☐	6. Are you now or have you ever been a defendant in any malpractice proceedings, regardless of the outcome?
☐	☐	7. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, **regardless of the outcome**? *(This includes withheld judgments and matters that have been expunged.)*
☐	☐	8. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice your medical profession with reasonable skill and safety? *(If you are receiving appropriate treatment that allows you to practice safely and without impairment, you may answer NO.)*

I, _____, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct; that I am the lawful holder of the degrees/credentials listed, and that such degrees/certificates were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board and information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practicing polysomnography related respiratory care.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information with this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my permit to practice polysomnography related respiratory care in the State of Idaho.

I further declare that the photo of me attached hereto was taken on or about _____, 20 _____, my age being _____.

State _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

(SEAL)

Notary Signature _____

My commission expires _____

_____

Signature of Applicant

VERIFICATION OF PROFESSIONAL EDUCATION

TO BE COMPLETED BY THE APPLICANT:

Full Name of Applicant:	
Address:	
Social Security Number:	**Date of Birth:**

_____

Applicant's Signature

TO BE COMPLETED BY REGISTRAR OR PROGRAM DIRECTOR: Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; Fax: (208) 334-3536.

Certificate of Completion Received:	**Date of Certificate:**
Degree Received:	**Date of Degree:**

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

_____
Please type or print name of Registrar/Director

_____
Signature of Registrar/Director

(SEAL)

_____
Name of School or Facility

_____
If changed, present name

_____
City **State** **Zip**

_____
Date of this Verification

SUPERVISOR AFFIDAVIT

TO BE COMPLETED BY THE APPLICANT:

*(This form is required for **provisional** polysomnography permit only.)*

Full Name of Applicant:

Address:

TO BE COMPLETED BY SUPERVISOR: Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; Fax: (208) 334-3536.

FACILITY

Must provide a Supervisor Affidavit to the Board for each facility Applicant is to practice polysomnography related respiratory care.

Name of Facility:

Address:

Telephone:

SUPERVISOR

Must be a currently licensed Idaho respiratory therapist or physician.

Name:

Address:

Telephone: **Idaho License No.:**

AFFIDAVIT OF SUPERVISOR

Applicant will work under my personal supervision, and I assume responsibility for the applicant's work.

(SEAL)

_____

Signature of Supervisor

State _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Signature _____

My commission expires _____

Authorization for Release of Information

This form is to be completed by the applicant with the name(s) of any other individual(s) or entity(s), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc, and returned with the application. **Without this completed form, the Board may only discuss the pending status with the applicant.**

☐ I authorize the following individuals to inquire about the status of my application (see below):

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

I hereby authorize and direct the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys at any time to release information regarding my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine to the individuals named above.

I further authorize the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys who have such information to consult with or discuss such information with any of the individuals named above.

Upon my knowledge and with legal consultation, I understand the nature of this Authorization for Release of Information with regard to my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine.

I, and my heirs, do hereby release the Idaho State Board of Medicine, Committee on Professional Discipline of the Idaho State Board of Medicine, and its members, employees, agents, officers, representatives, and attorneys, from all liability and all claims of any nature whatsoever pertinent to the information released.

Name of Applicant: _____
(First, Middle, Last)

Signature: _____ Date: _____

State of: _____
:ss
County of: _____

On this ____ day of _____, 20____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

I WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

_____
Notary Public for _____

Residing at: _____

My commission expires: _____