

## **GENERAL INFORMATION FOR POLYSOMNOGRAPHIC TECHNOLOGIST, TECHNICIAN & TRAINEE LICENSURE**

### **Criminal History Background Check**

The NM Medical Board requires that all applicants for initial licensure **submit fingerprints** and other information necessary for a state and national criminal background check, at their cost.

Like other state medical boards around the country, the NM Medical Board will conduct criminal background checks in order to fulfill its statutory mandate to protect the health and safety of the NM public. The applicant is responsible for any costs associated with obtaining fingerprints.

The criminal background check will not slow down your license application. An application for initial licensure will not be considered complete until the required fingerprint cards and forms have been received in the Board office. However, otherwise completed applications will be processed pending the outcome of the background check, and licenses may be granted while the screening is still pending. If the background check reveals a felony or a violation of the Medical Practice Act the licensee will be notified and the Board will determine if disciplinary action will be taken against the licensee.

### **Fingerprint cards cannot be downloaded from the Board's web site.**

Blank fingerprint cards will be sent to you upon receipt of your application and application fee.

### **Fees**

The application fee of \$150 plus the criminal background check fee of \$36 for a total of \$186 is payable in U.S. funds by cashier's check, money order, check, MasterCard or Visa. Applications will not be processed until the application fee has been received. **All fees are nonrefundable.**

### **Education**

An applicant must provide proof of:

- High school graduation (copy of diploma or GED certificate); **OR** degree from a level of higher education (copy of diploma or copy of transcripts posting degree).

#### **AND proof of completion of:**

- A Polysomnographic Educational Program that is accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP);
- **OR** graduated from a Respiratory Care Educational Program that is accredited by the CAAHEP and completed the curriculum for a polysomnography or sleep diagnostic specialist certificate established and accredited by the committee on accreditation for respiratory care of the CAAHEP;
- **OR** graduated from an Electroneurodiagnostic Technologist Educational Program with a polysomnographic technology track that is accredited by the CAAHEP;
- **OR** successful completion of a sleep technologist educational program that is accredited by the AASM ("A-Step Introductory Course" or "A-Step Self Study Modules"); *this option will expire two years after the date that at least three Polysomnographic Technologist Education Programs in New Mexico have been accredited by the CAAHEP.*

**WAIVER OF THE EDUCATIONAL REQUIREMENT:** The Board may waive the above educational requirements for an individual continuously engaged in the practice of polysomnography on or before July 1, 2008. To be eligible for the waiver, the applicant must meet all other requirements for licensure.

## **Certification Requirements**

**BRPT** – Board of Registered Polysomnographic Technologists, a national agency for credentialing polysomnographic technologists.

- **RPSGT** - Registered Polysomnographic Technologist through the BRPT.

**NBRC** – National Board for Respiratory Care, a national organization that credentials respiratory therapists, and provides an exam to further certify respiratory therapists as sleep disorders specialists.

**NBRC-SDS** - National Board for Respiratory Care – Sleep Disorders Specialist Examination.

An applicant must hold current BRPT, either RPSGT or CPSGT (or another national entity equivalent to BRPT as approved by the Board) **OR** NBRC-SDS Certification. **Polysomnographic Technicians not currently certified by BRPT (or equivalent) OR NBRC-SDS will be issued a Temporary Permit. SEE TECHNICIAN PERMIT BELOW FOR INSTRUCTIONS.**

## **Work Experience Affidavit**

You may use the “Work Experience Affidavit” only if a clinic you have worked at within the last five years has shut down and you have no further contact with any of your supervisors from said clinic.

The affidavit is to be filled out by the applicant and then notarized.

## **Common Places to Look for a Notary**

1. City and town halls
2. Courts
3. Banks
4. Law offices
5. Insurance companies
6. Drug stores and pharmacies
7. In the phone book under "Notary Public"

The applicant is responsible for mailing the completed affidavit to the Board office along with their application. Board staff will verify the closure of the clinic.

## **Application Processing**

Application processing times vary based on the amount of time it takes to have all the required documents sent into the Board office. It is the applicant's responsibility to assure that their application is complete in every detail, including having all of the required verifications and documentation sent into the Board office. **You may not practice as a Polysomnographic Technologist, Technician or Trainee unless you have been issued a license by the New Mexico Medical Board.**

It is solely the applicant's responsibility to contact the Board office to check the status of a pending application. Licensing staff has a “Status” phone line you may call before 3:00 pm Monday through Friday, leave your name and phone number where you can be reached AFTER 3:00 pm and a licensing staff member will pull your file and call you back the same day with a complete status. The status line phone number is 505-476-7245.

## INSTRUCTIONS FOR COMPLETING THE POLYSOMNOGRAPHIC TECHNOLOGIST APPLICATION

### Procedures

Complete the application in its entirety. Please **type or print legibly in black or blue ink.**

1. Board Application

Complete all application pages (1-6). You must respond to **all** components of the application as instructed.

2. Education

- Proof of high school graduation (copy of diploma or GED certificate); **OR** proof of degree from a level of higher education (copy of diploma or copy of transcripts posting degree).

**AND**

- Proof of completion of a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP).

The Board considers the following documents as acceptable: official transcripts posting certification sent directly to the Board office by the program, **or** an official certificate of completion sent directly to the Board office by the program, **or** completion of the Board's Education Certification Form by the program director or administrator sent directly to the Board office.

3. BRPT or NBRC-SDS Certification

You must have **BRPT** (or a national entity equivalent to BRPT as approved by the Board) or **NBRC** submit proof of certification directly to the Board via USPS, fax or electronic mail.

4. ACLS/CPR/Automated External Defibrillator Certification

Provide proof of current certification of successful completion of formal training in basic cardiopulmonary resuscitation **and** in the application and management of an automated external defibrillator. (Copy of certificate of completion or certification card).

5. Verification of Licensure / Registration

You must have each state licensing authority that has ever issued you a Polysomnographic Technologist license or **any other health related license/registration** verify the standing of that license/registration directly to the Board. Use the enclosed form entitled "Verification of Licensure/Registration." Make photocopies as required. Complete the release on the top half of the form and send one copy to each jurisdiction. **These completed verifications must be sent directly to the Board office from the licensing authority.**

6. Letters of Recommendation

You must have two (2) Professional Recommendation forms completed and sent directly to the Board by **Polysomnographic Technologists or Physicians** in the United States, or other healthcare professionals who have personal knowledge of the applicant's moral character and competence to practice as a polysomnographic technologist.

7. Work Experience Verification

You must have the chief of staff or administrator in each and every hospital or health facility where you have been employed during the past five (5) years complete the Work Experience Verification form(s) and return the completed form(s) directly to the New Mexico Medical Board.

You may use the "Work Experience Affidavit" only if a clinic you have worked at within the last five years has shut down and you have no further contact with any of your supervisors from said clinic. The affidavit is to be filled out by the applicant and then notarized (See above for possible notary locations). The applicant is responsible for mailing the completed affidavit to the Board office along with their application. Board staff will verify the closure of the clinic.

8. Applicant's Oath

You must complete the form entitled "Applicant's Oath" in its entirety AND affix a recent (less than 6 months) color **passport-quality photograph\*** of yourself in the designated space.

**\*Passport-quality color photograph** - Approximate size is 2x2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper. Scanned or computer-generated photographs should have no visible pixels or dots.

9. Supervising Statement of Responsibility/Affidavit Form:

The Technologist is responsible for submitting to the Board upon application the Board's Supervising Statement of Responsibility/Affidavit Form. If the Technologist is working at two different locations with two different supervisors, two Supervising Statements of Responsibility must be filed with the New Mexico Medical Board. If the Technologist is working at satellite locations under the supervision of one supervisor, the satellite locations must be listed in the designated location on the Supervising Statement of Responsibility/Affidavit Form.

10. Submitting The Board Application

Attach your payment to the front of the application. Make payment in U.S. funds to the New Mexico Medical Board. Do not send cash. Mail your application, appropriate fee, Applicant's Oath and any other supporting documents to:

***New Mexico Medical Board  
2055 S. Pacheco Street  
Building 400  
Santa Fe, New Mexico 87505***

**Technician Permit**

Polysomnographic Technicians not currently certified by BRPT (or equivalent) **OR** NBRC-SDS will be issued a **Temporary Technician Permit**.

A **Temporary Technician Permit** is valid for no more than two years from the date of the technician's graduation. The Temporary Permit may be renewed for up to one year beyond the original two-year expiration date and upon payment of the renewal fee (\$50.00). The Temporary Permit can only be renewed one time.

The holder of a **Temporary Permit** can only work under the general supervision of a New Mexico Licensed physician. **The Technician is responsible for submitting to the Board upon application the specific program or protocol of work planned in addition to the Board's Supervising Statement of Responsibility/Affidavit Form.**

## INSTRUCTIONS FOR COMPLETING THE POLYSOMNOGRAPHIC TECHNICIAN APPLICATION

### Procedures

Complete the application in its entirety. Please **type or print legibly in black or blue ink**.

1. Board Application

Complete all application pages (1-6). You must respond to **all** components of the application as instructed.

2. Education

- Proof of high school graduation (copy of diploma or GED certificate); **OR** proof of degree from a level of higher education (copy of diploma or copy of transcripts posting degree).

**AND**

- Proof of completion of a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP).

The Board considers the following documents as acceptable: official transcripts posting certification sent directly to the Board office by the program, **or** an official certificate of completion sent directly to the Board office by the program, **or** completion of the Board's Education Certification Form by the program director or administrator sent directly to the Board office.

3. ACLS/CPR/Automated External Defibrillator Certification

Provide proof of current certification of successful completion of formal training in basic cardiopulmonary resuscitation **and** in the application and management of an automated external defibrillator. (Copy of certificate of completion or certification card).

4. Verification of Licensure / Registration

You must have each state licensing authority that has ever issued you a Polysomnographic Technologist license or **any other health related license/registration** verify the standing of that license/registration directly to the Board. Use the enclosed form entitled "Verification of Licensure/Registration." Make photocopies as required. Complete the release on the top half of the form and send one copy to each jurisdiction. **These completed verifications must be sent directly to the Board office from the licensing authority.**

5. Letters of Recommendation

You must have two (2) Professional Recommendation forms completed and sent directly to the Board by **Polysomnographic Technologists or Physicians** in the United States, or other healthcare professionals who have personal knowledge of the applicant's moral character and competence to practice as a polysomnographic technologist.

6. Work Experience Verification

You must have the chief of staff or administrator in each and every hospital or health facility where you have been employed during the past five (5) years complete the Work Experience Verification form(s) and return the completed form(s) directly to the New Mexico Medical Board.

You may use the "Work Experience Affidavit" only if a clinic you have worked at within the last five years has shut down and you have no further contact with any of your supervisors from said clinic. The affidavit is to be filled out by the applicant and then notarized (See above for possible

notary locations). The applicant is responsible for mailing the completed affidavit to the Board office along with their application. Board staff will verify the closure of the clinic.

7. Applicant's Oath

You must complete the form entitled "Applicant's Oath" in its entirety AND affix a recent (less than 6 months) color **passport-quality photograph\*** of yourself in the designated space.

**\*Passport-quality color photograph** - Approximate size is 2x2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper. Scanned or computer-generated photographs should have no visible pixels or dots.

8. Supervising Statement of Responsibility/Affidavit Form:

The Technician is responsible for submitting to the Board upon application the specific program or protocol of work planned in addition to the Board's Supervising Statement of Responsibility/Affidavit Form. If the Technician is working at two different locations with two different supervisors, two Supervising Statements of Responsibility must be filed with the New Mexico Medical Board. If the Technician is working at satellite locations under the supervision of one supervisor, the satellite locations must be listed in the designated location on the Supervising Statement of Responsibility/Affidavit Form.

9. Submitting the Board Application

Attach your payment to the front of the application. Make payment in U.S. funds to the New Mexico Medical Board. Do not send cash. Mail your application, appropriate fee, Applicant's Oath and any other supporting documents to:

***New Mexico Medical Board  
2055 S. Pacheco Street  
Building 400  
Santa Fe, New Mexico 87505***

**INSTRUCTIONS FOR COMPLETING THE POLYSOMNOGRAPHIC TRAINEE APPLICATION**

**Procedures**

Complete the application in its entirety. Please **type or print legibly in black or blue ink.**

1. Board Application

Complete all application pages (1-6). You must respond to **all** components of the application as instructed.

2. Education

- Proof of high school graduation (copy of diploma or GED certificate); **OR** proof of degree from a level of higher education (copy of diploma or copy of transcripts posting degree).

## AND

- Proof of enrollment in a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP).

The Board considers the following documents as acceptable: official transcripts posting certification sent directly to the Board office by the program, **or** an official certificate of completion sent directly to the Board office by the program, **or** completion of the Board's Education Certification Form by the program director or administrator sent directly to the Board office.

### 3. ACLS/CPR/Automated External Defibrillator Certification

Provide proof of current certification of successful completion of formal training in basic cardiopulmonary resuscitation **and** in the application and management of an automated external defibrillator. (Copy of certificate of completion or certification card).

### 4. Verification of Licensure / Registration

You must have each state licensing authority that has ever issued you a Polysomnographic Technologist license or **any other health related license/registration** verify the standing of that license/registration directly to the Board. Use the enclosed form entitled "Verification of Licensure/Registration." Make photocopies as required. Complete the release on the top half of the form and send one copy to each jurisdiction. **These completed verifications must be sent directly to the Board office from the licensing authority.**

### 5. Letters of Recommendation

You must have two (2) Professional Recommendation forms completed and sent directly to the Board by **Polysomnographic Technologists or Physicians** in the United States, or other healthcare professionals who have personal knowledge of the applicant's moral character and competence to practice as a polysomnographic technologist.

### 6. Work Experience Verification or Clinic Closure Affidavit

You must have the chief of staff or administrator in each and every hospital or health facility where you have been employed during the past five (5) years complete the Work Experience Verification form(s) and return the completed form(s) directly to the New Mexico Medical Board.

You may use the "Work Experience Affidavit" only if a clinic you have worked at within the last five years has shut down and you have no further contact with any of your supervisors from said clinic. The affidavit is to be filled out by the applicant and then notarized (See above for possible notary locations). The applicant is responsible for mailing the completed affidavit to the Board office along with their application. Board staff will verify the closure of the clinic.

### 7. Applicant's Oath

You must complete the form entitled "Applicant's Oath" in its entirety AND affix a recent (less than 6 months) color **passport-quality photograph\*** of yourself in the designated space.

**\*Passport-quality color photograph** - Approximate size is 2x2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper. Scanned or computer-generated photographs should have no visible pixels or dots.

### 8. Supervising Statement of Responsibility/Affidavit Form:

The Technician is responsible for submitting to the Board upon application the specific program or protocol of work planned in addition to the Board's Supervising Statement of Responsibility/Affidavit Form. If the Trainee is working at two different locations with two different supervisors, two Supervising Statements of Responsibility must be filed with the New Mexico Medical Board. If the Trainee is working at satellite locations under the supervision of one supervisor, the satellite locations must be listed in the designated location on the Supervising Statement of Responsibility/Affidavit Form.

9. Submitting the Board Application

Attach your payment to the front of the application. Make payment in U.S. funds to the New Mexico Medical Board. Do not send cash. Mail your application, appropriate fee, Applicant's Oath and any other supporting documents to:

***New Mexico Medical Board  
2055 S. Pacheco Street  
Building 400  
Santa Fe, New Mexico 87505***



## New Mexico Medical Board

### Polysomnographic Technologist/Technician/Trainee Application

Date of Application: \_\_\_\_\_

Application For:

**Technologist**  
(Completed educational Requirement & is BRPT Certified)

**Technician**  
(Completed educational requirement)

**Trainee**  
(Enrolled in approved educational program)

Application fee: **\$150.00**  
Background Check fee: **\$ 36.00**  
**TOTAL COST: \$186.00**

**\$150.00**  
**\$ 36.00**  
**\$186.00**

**\$ 36.00**  
**\$ 36.00**

### Demographics

<b>Name</b>			
	Last	First	Middle
<b>Other Names Used</b>			

<b>Gender</b>	M	F	<b>Place of Birth</b>		<b>Citizenship</b>	
<b>Immigration Status</b>					<b>INS Certification #</b>	
<b>*Social Security Number</b>					<b>Date of Birth</b>	
<b>Current Practice Name</b>						
Street						
City		State		Zip Code		
Telephone Number			Facsimile			
*Office Manager or Contact Person:						
* <b>E-Mail Address</b> (confidential)						
* <b>Current Mailing Address</b> (if different from above -confidential unless no practice address indicated)						
*Street						
*City		*State		*Zip Code		
Telephone Number			Facsimile			
<b>What are your immediate or future Practice Plans in New Mexico?</b>						
<b>Home Address (Required)</b>			<b>*Telephone Number</b>			
Street						
*City		*State		*Zip		

\*Information Confidential

**Education** (Please attach a separate sheet, if necessary.)

Education					
High School/GED					
City				State/Country	Zip Code:
Dates Attended	From:	To:	Graduation Date		
College or University					
City				State/Country	Zip Code:
Dates Attended	From:	To:	Degree	Graduation Date	
Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP)					
College/ University/Program Name					
City				State/Country	Zip Code:
Dates Attended	From:	To:	Degree	Graduation Date	
College/University/Program Name					
City				State/Country	Zip Code:
Dates Attended	From:	To:	Degree	Graduation Date	
Graduate Education					
College or University					
City				State/Country	Zip Code:
Dates Attended	From:	To:	Degree	Graduation Date	
College or University					
City				State/Country	Zip Code:
Dates Attended	From:	To:	Degree	Graduation Date	

**Licensure-Registration-Certification Information**

State Professional License/Certification Number					
State		Issue Date		Expiration Date	Pending <input type="checkbox"/>
All Other State License Numbers (regardless of status - attach separate list if necessary.)					
State	Number	Issue Year	Expiration Date		

**ACLS/CPR Certification:** \_\_\_\_\_  
 Month/Year \_\_\_\_\_ Number \_\_\_\_\_

**Application and Management of an Automated External Defibrillator Certification:**  
 \_\_\_\_\_  
 Month/Year \_\_\_\_\_ Number \_\_\_\_\_

**Certifying Examination:**

- BRPT** (Board of Registered Polysomnographic Technologists), RPSGT.

Date of Exam: \_\_\_\_\_ Credentialing Certification No.: \_\_\_\_\_  
 Month/Year \_\_\_\_\_

- NBRC-SDS** (National Board for Respiratory Care)

Date of Exam: \_\_\_\_\_  
 Month/Year \_\_\_\_\_

**Work History** Please list all previous experience for the past 15 years or since graduation from a professional program, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
<b>Location</b>		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

Applicant Name \_\_\_\_\_ Date \_\_\_\_\_

**Professional References** Please list three professional peers familiar with your professional performance in the past 5 years.

<b>(1) Name and Title</b>				
Address				
City		State	Zip Code	
Telephone Number			Facsimile	
<b>(2) Name and Title</b>				
Address				
City		State	Zip Code	
Telephone Number			Facsimile	
<b>(3) Name and Title</b>				
Address				
City		State	Zip Code	
Telephone Number			Facsimile	

**Professional Practice Questions** Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever been denied professional liability insurance coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Have you ever been named as a defendant in any criminal proceedings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<p><b>12. a.</b> Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>b.</b> Are any currently held licenses pending investigation or being challenged?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>13.</b> Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>14.</b> Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? <b>If yes, please provide the following information on the attached Malpractice History form for each case:</b></p> <ul style="list-style-type: none"> <li>• Name, age, sex of patient/claimant.</li> <li>• Date(s) and type of treatment and/or surgery, which led to the allegations against you.</li> <li>• Nature of allegations in claims/suits. Specify whether a suit was ever filed.</li> <li>• Names of other practitioners and hospital, if any, involved in claims or suit.</li> <li>• Disposition or current status of claim or suit (be specific).</li> <li>• Name of insurance carrier defending you.</li> <li>• Name of defense attorney.</li> </ul>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>15.</b> Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>16.</b> In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? <b>If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.</b></p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p><b>17.</b> Have you ever, for any reason:</p> <p><b>a)</b> Resigned from a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP)?</p> <p><b>b)</b> Withdrawn from a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP)?</p> <p><b>c)</b> Been suspended, dismissed, or expelled from a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP)?</p> <p><b>d)</b> Been placed on probation or remediation, including academic probation or remediation, by a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP)?</p> <p><b>e)</b> Taken a leave of absence or break from, or had any interruptions or extensions in, a Polysomnographic Program, or Respiratory Care Program, or Electroneurodiagnostic Technologist Program, or AASM Accredited Sleep Technologist Program (A-STEP) for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.**

**APPLICANT'S OATH**

I, \_\_\_\_\_, hereby certify that I am the person pictured below and named in this application for a license to practice as a Polysomnographic Technician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

**ATTACH  
RECENT  
PASSPORT-  
QUALITY\*  
PHOTOGRAPH  
THAT WILL FIT IN  
THIS SPACE**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name \_\_\_\_\_ Date \_\_\_\_\_  
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Thank you for your cooperation.

**New Mexico Medical Board**  
2055 S. Pacheco St.  
Building 400  
Santa Fe, NM 87505  
(505) 476-7220

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**PROFESSIONAL RECOMMENDATION**

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The New Mexico Medical Board requires the completion of this Professional Recommendation by an individual who has personal knowledge of my moral character and competence to practice as a Polysomnographic Technologist. This form is required as part of my application for licensure. **All** elements in the section below **must** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, **DIRECTLY** to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

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Applicant's Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Applicant' Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING INDIVIDUAL**  
**The information on this form is NOT a public document.**

1. Date and type of service: This individual served with me as \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_  
Month/Year Month/Year Location

2. Please evaluate: (Please indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge _____				
Clinical judgment _____				
Relationship with patients _____				
Ethical/professional conduct _____				
Ability to communicate _____				
Clinical skills _____				

3. Recommendation: (please indicate with a check mark)

- 1. Recommend highly and without reservation \_\_\_\_\_
- 2. Recommend as qualified and competent \_\_\_\_\_
- 3. Recommend with some reservation (explain) \_\_\_\_\_
- 4. Concerns (explain) \_\_\_\_\_

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments. (Attach a separate page, if necessary).

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5. The above report is based on: (please indicate with check mark)

- 1. Close personal observation \_\_\_\_\_
- 2. General impression \_\_\_\_\_
- 3. A composite of evaluations \_\_\_\_\_
- 4. Other \_\_\_\_\_

Name (Please Print): \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**POLYSOMNOGRAPHY WORK EXPERIENCE AFFIDAVIT**

I was employed as a \_\_\_\_\_ from  
*[job title in a health-related field]*

\_\_\_\_\_ *[day of month]* day of \_\_\_\_\_ *[month]*, 20\_\_\_\_ to

\_\_\_\_\_ *[day of month]* day of \_\_\_\_\_ *[month]*, 20\_\_\_\_ by

\_\_\_\_\_  
*[business name]*

located at \_\_\_\_\_  
*[full address including city, state, and ZIP code]*

I have been unable to contact said business for verification of the above employment for  
the following reason: \_\_\_\_\_  
*[set forth affiant's statement of facts]*

**I affirm that the above information is, to the best of my knowledge, true and correct and that my  
performance as an employee of said business was satisfactory and would not, if known, adversely  
affect any determination by the New Mexico Medical Board in my behalf.**

\_\_\_\_\_  
*[signature of affiant]*

\_\_\_\_\_  
*[typed name of affiant]*

\_\_\_\_\_  
*[address of affiant, line 1]*

\_\_\_\_\_  
*[address of affiant, line 2]*

**State of New Mexico**  
**County of \_\_\_\_\_**

Subscribed and sworn to before me, this \_\_\_\_\_ *[day of month]* day of  
\_\_\_\_\_ *[month]*, 20\_\_\_\_.

*[Notary Seal:]*

\_\_\_\_\_  
*[signature of Notary]*

\_\_\_\_\_  
*[typed name of Notary]*

NOTARY PUBLIC  
My commission expires: \_\_\_\_\_, 20\_\_\_\_.

**New Mexico Medical Board**  
2055 S. Pacheco St.  
Building 400  
Santa Fe, NM 87505  
(505) 476-7220

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**VERIFICATION OF LICENSURE**

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I am applying for a Polysomnographic Technologist license in the State of New Mexico. The New Mexico Medical Board requires that your Board complete this form or its equivalent so that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, directly to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505

\_\_\_\_\_  
Print/Type Full Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Date Issued

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

---

**THE SECTION BELOW SHOULD BE COMPLETED BY THE APPLICABLE LICENSING BOARD**

Name of Licensing Authority: \_\_\_\_\_

Name of Licensee: \_\_\_\_\_

License Type: \_\_\_\_\_ License Number: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

1. Is license current?  Yes  No If "No" why not? \_\_\_\_\_

2. Has licensee ever been disciplined by your Board?  Yes  No

If "Yes": Revoked  Yes  No

Suspended  Yes  No

Stipulated  Yes  No

On Probation  Yes  No

Dates: \_\_\_\_\_

3. Has this licensee's license ever been: Allowed to lapse for non-payment of fees?  Yes  No

Placed on Retired or Inactive status?  Yes  No

Surrendered Voluntarily?  Yes  No

4. Are there any formal charges pending against this license?  Yes  No

5. Has licensee ever been investigated or requested to appear before your Board for any serious matter?  Yes  No

**If you answered "YES" to questions 3-5 please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).**

\_\_\_\_\_  
\_\_\_\_\_  

Please Affix  
Board Seal Here

\_\_\_\_\_  
Signature of Board Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone Number