STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr., Ste 140
Boise, Idaho 83704
(208) 327-7000
FAX (208) 327-7005
E-Mail info@bom.idaho.gov
Website bom.idaho.gov

TO: Idaho Permit Applicants

FROM: Idaho State Board of Medicine

RE: Idaho Polysomnography Related Respiratory Care Permit

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.

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GENERAL CHECKLIST FOR POLYSOMNOGRAPHY APPLICANTS

*** Questions? E-mail claudia.lawson@bom.idaho.gov ***

Fee must accompany application. **APPLICATION WILL NOT BE PROCESSED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE.** Amount is indicated on application. **NOTE:** Applicants with an active Idaho Respiratory Therapist license may apply for and obtain a permit for polysomnography related respiratory care without paying an application fee. *Fees are nonrefundable.*

Applications must be on forms provided by the Board and all sections must be complete. Please type or print in ink. Applications must be legible.

Front page of application: If applicant has not applied for licensure/registration/permit in other states, write "Not Applicable" in the appropriate section.

Back page of application:

Chronological account of time – Account for **all** periods of time beginning with the month applicant last received training/education up to the present time, leaving no gap in time of more than one month. Attach additional pages if necessary.

Questions – Answer all questions 1-8. Provide details, for *YES* answers, on a separate sheet. Court documents will be required, if applicable.

Photo – Does not need to be a professional photo. A **clear** and **in focus** 3"x4" snapshot taken of the head and shoulders only, with a digital camera, is a good choice. Passport photos are acceptable.

Notarized – Application must be notarized and signed in **all** of the appropriate places by a notary public.

Certificate of Professional Education: Fill in the top section. Be sure to indicate the certificate/degree **and** the field of study, the date certificate/degree was received, and sign **at the bottom** of the section. Send this form to the school (Program Director or Registrar) where applicant received professional education. The school will then send the form to the Board of Medicine.

Certificates of Recommendation (Form 4 & 5): Fill in the top section. Send this form to **two** individuals who have known the applicant professionally for at least **one** year (**no relatives**). Recommendations must be on the form provided or on letterhead addressed to the Board of Medicine. Names and addresses must be legible.

Verification of Registration/Licensure/Permit: This form may be duplicated. This is required from **every state** where the applicant has ever held a registration/license/permit and must come directly from the state to the Board. **NOTE:** Most states require a fee for this service, paid in advance. It is strongly suggested that you contact the state(s) before sending your request to prevent delays and to determine the best way to send required fees.

CPR Certification Verification: Applicant must be currently certified in cardiopulmonary resuscitation (CPR). Please provide a photocopy of current CPR card.

FAXED and emailed supporting documents can be accepted, but the hard copy is preferred. The applicant's section of the application **cannot** be faxed. FAX# (208) 327-7005.

PLEASE NOTE: Forms received prior to receipt of application and licensure fee will be held in a "Misc. Forms" file for up to one year. After one year, the forms will be thrown away.

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 a permit will be granted.

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0058 · (208) 327-7000

Express Mail: 1755 Westgate Drive, #140 · Boise, ID 83704

APPLICATION - POLYSOMNOGRAPHY RELATED RESPIRATORY CARE PERMIT

FOR USE OF THE BOARD					
1. Prof. Education	2. Training	BRPT	4. Recommendation	5. Recommendation	Received
6. Verification	7. Supervisor	CPR	NPDB-HIPDB	SSN Disclosure	Fee

Before completing, please see instructions.

I hereby apply for:

- [x] PSG Technologist - Fee $100
- [ ] PSG Technician - Fee $100
- [ ] PSG Trainee (Temporary Permit) - Fee $45

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.

Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE

First Name	Middle Name	Last Name
Address (*Street, City, State, Zip*)		Telephone
Email Address		Social Security No.
Place of Birth (*City and State*)		Date of Birth (*Month, Date, Year*)

Height (*Ft., In.*)	Weight	Hair	Eyes	Complexion	Scars, Marks	...
			...	...		...

NAME AND LOCATION OF SCHOOLS	**FROM (*Month, Day, Year*)**	**TO (*Month, Day, Year*)**
High School		
College/University		
Polysomnography Program		
Postgraduate Study		

BRPT Registry Number: _____

I HAVE APPLIED FOR LICENSURE/REGISTRATION OR PERMIT IN THE FOLLOWING STATES OR COUNTRIES	**Year**	**GRANTED CURRENT**				**NUMBER**	**APPLICATION BASED UPON**	
		Yes	**No**	**Yes**	**No**		**Endorse.**	**Exam.**
		☐	☐	☐	☑		☐	☐
		☐	☐	☐	☐		☐	☐
		☐	☐	☐	☐		☐	☐
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		☐	☐	☐	☐		☐	☐
		☐	☐	☐	☐		☐	☐

In chronological order account for all periods of time beginning with the month applicant last received training/education up to the present time, leaving no gap in time of more than one month (employed, unemployed, studying for the exam, military service, extended vacation, etc.) Attach additional pages if necessary.

FROM (Month, Year)	TO (Month, Year)	NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION	EMPLOYER

NOTE

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

Proof photos, negatives, copies, and instant photos are not acceptable.

DO NOT STAPLE PHOTO TO APPLICATION

CERTIFICATION

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

	Y	N	
1.	☐	☐	Have you ever failed a licensure exam?
2.	☐	☐	Have you ever been refused a professional license/registration?
3.	☐	☐	Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome?
4.	☐	☐	Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct?
5.	☐	☐	Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration/permit?
6.	☐	☐	Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice polysomnography related respiratory care with reasonable skill and safety?
7.	☐	☐	Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action?
8.	☐	☐	Do you currently have or have you had problems with the use of alcohol, stimulants habit forming and/or illegal drugs in the past five years which in any way impairs or limits your ability to practice polysomnography related respiratory care with reasonable skill and safety?

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

CERTIFICATE OF PROFESSIONAL EDUCATION

Please have the following completed by the appropriate educational institution and return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. #140, Boise, ID 83704; Fax: (208) 327-7005; Fax: (208) 327-7005.

Full Name of Applicant:	
Address:	
Social Security Number:	Date of Birth:
Associate Degree:	Date of Degree:
Certificate of Completion:	Date of Certification:

Dates of Attendance:	**From (Date)**	**To (Date)**
First Year		
Second Year		
Third Year		
Fourth Year		

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 Director/ Registrar

_____
Signature of Director/Registrar

_____
Name of School or Facility

(SEAL)

_____
If changed, present name

_____
City State Zip Code

_____
Date of This Certification

_____
Applicant's signature

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (Note: Two certificates of recommendation are required. Please duplicate this form.) Recommendations should be from persons who have known the applicant professionally for at least one year.

Applicant's Name: _____

Address: _____

_____

Do you request that this information be confidential? Yes No

TO: Idaho State Board of Medicine:

I have known _____ for _____ years, from _____ to _____ while he/she was studying or practicing polysomnography related respiratory care. To the best of my knowledge he/she is of good moral and professional character and ethics.

Additional Comments:

Signature _____

Printed Name _____

Date _____

Address _____

_____

Profession _____

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (Note: Two certificates of recommendation are required. Please duplicate this form.) Recommendations should be from persons who have known the applicant professionally for at least one year.

Applicant's Name:_____

Address:_____

_____

Do you request that this information be confidential? ___Yes ___No

TO: Idaho State Board of Medicine:

I have known _____ for _____ years, from _____ to _____ while he/she was studying or practicing polysomnography related respiratory care. To the best of my knowledge he/she is of good moral and professional character and ethics.

Additional Comments:

Signature _____

Printed Name _____

Date _____

Address _____

_____

Profession _____

VERIFICATION OF LICENSURE/REGISTRATION

Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (If additional forms are needed, this form may be duplicated.)

I am applying for licensure to practice polysomnography related respiratory care in the State of Idaho. The Idaho State Board of Medicine requires verification of registration/licensure from each state wherein I hold or have held registration/licensure. This is your authority to release any information in your files favorable or otherwise, directly to the Idaho State Board of Medicine, at the address indicated above.

Applicant's Name: _____

Applicant's Address: _____

My Registration/License/Permit No. is: _____

State of:_____ Registration/License/Permit No.:_____ Issue Date:_____

Name of Registrant/Licensee: _____

Issued by:_____ Endorsement/Reciprocity with:_____

_____ Examination (BRPT)

Status: Current Yes _____ No _____ Expiration Date_____

Do you have any record of disciplinary or legal action that should be considered with this polysomnographer's application? Yes _____ No _____

Comments:

_____
Signature

_____
Title

_____
Date

(Board Seal)

_____
State Board

Verification - Not an Endorsement

STATEMENT REGARDING DISCLOSURE OF SOCIAL SECURITY NUMBERS

The Idaho State Board of Medicine (hereinafter Board) requires disclosure of social security numbers on all applications for initial licensure and renewal. Disclosure of social security numbers is mandatory for purposes of enforcing child support orders under Idaho Code § 7-1416 and compliance with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank, as required by 45 CFR §§ 61.1 *et seq*. If this Board is required to make a report about an applicant or licensee to the Idaho Department of Health and Welfare or either of these data banks, the report must contain that individual's social security number. Failure to provide a social security number for these mandatory purposes will result in denial of an application for initial licensure or renewal.

An applicant for initial licensure or renewal may also voluntarily disclose his or her social security number for release to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation, such as the Federation of State Medical Boards' Physician Data Center. The Center compiles information about individual applicants and licensees and transmits that information to other licensing boards in order to coordinate licensure and disciplinary activities between the individual States. Such disclosure is for identification purposes only. Social security numbers will not be released for any other purpose not provided for or allowed by law.

I do _____ do not _____ give the Idaho State Board of Medicine permission to disclose my social security number to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation.

DATED This _____ day of _____, 20____.

_____ _____

Applicant's signature Applicant's printed name