

7 List the supervising physician(s) who will verify your experience for authorization as a polysomnographic technologist.

Assigned Number	Name of Supervising Physician and Address of Experience Setting	Dates of Experience	
		From	To
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Attestation

I declare and affirm that the statements made in the foregoing application, including accompanying statements are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of qualification and may lead to a filing of charges of professional misconduct.

 Applicant's Signature _____ / _____ / _____
mo. day yr.

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Polysomnographic Technology Unit, 89 Washington Avenue, Albany, NY 12234-1000.