

Section II: Supervising Physician Verification of Professional Experience

Instructions to Supervising Physician: Complete Section II, sign and date the attestation and send both pages of this form directly to the address at the end of this form. **This form will not be accepted if returned by the applicant.**

Applicant Name: _____
(Section I, item 3)

A. Supervising Physician Qualifications:

Supervising Physician's Name: _____

I am a licensed physician in the jurisdiction of _____

License number (Attach a copy of your license if other than New York) _____ Date licensed _____

I (check one): am/was the owner of the applicant's work setting during the dates listed in item B.

(You must check one) am/was employed or engaged by the applicant's work setting during the dates listed in item B.

other, please explain: _____

B. Experience Information: I am attesting that the applicant practiced polysomnographic technology (defined below) under my supervision for at least 21 clinical hours per week as follows:

Name of setting where experience took place

Address of setting where experience took place

City

State

Zip Code

Dates of Experience: From _____ / _____ / _____ To _____ / _____ / _____ Present
mo. day yr. mo. day yr.

The term "practice of polysomnographic technology" means the process of collecting, analyzing, scoring, monitoring and recording physiologic data during sleep and wakefulness to assist the supervising physician in the clinical assessment and diagnosis of sleep/wake disorders and other disorders, syndromes and dysfunctions that either are sleep related, manifest during sleep or disrupt normal sleep/wake cycles and activities. The practice of polysomnographic technology shall include the non-invasive monitoring, diagnostic testing, and initiation and delivery of treatments to determine therapeutic levels of inspiratory and expiratory pressures for individuals suffering from any sleep disorder, as listed in an authoritative classification of sleep disorders acceptable to the department, under the direction and supervision of a licensed physician who is available for consultation at all times during the provision of polysomnographic technology services in any setting. (See Section 79-4.8(b) for allowed services.)

Supervising Physician Attestation

I declare and affirm under penalty of perjury that the statements made in the foregoing application, including any attached statements, are true, complete and correct and that the experience I am attesting to meets the definition of polysomnographic technology practice.

Check here if you are attaching additional information.

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print Name: _____

Title: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

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.