

Section II: Certification of Supervision

Instructions to Supervisor: Complete this Section to certify that the permittee will be employed under the supervision of a licensed physician and a currently registered New York State licensed health care provider whose scope of practice includes all of the tasks he or she will be supervising. The applicant may not practice polysomnographic technology until the limited permit is issued. Limited permits expire one year from the date of issue and may be renewed for one additional year.

1. Applicant's name: _____

2. Supervisor:

Name: _____

Check one:

I am a licensed physician and the applicant named above will be under my direction and supervision during his employment.

License number: _____ Date license issued: _____ Jurisdiction: _____

OR

I am a currently registered, New York State licensed health care provider and the applicant named above will be under my direct and immediate supervision.

Profession you are licensed to practice: _____

New York State license number: _____ Date license issued: _____

Street: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____ E-mail: _____

3. Practice setting:

Name: _____

Street: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____ E-mail: _____

Attestation

I certify that the applicant named in Section I will be employed under my supervision. I declare and affirm that the information provided in the foregoing certification is true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for disciplinary action against my license.

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

Print name : _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.