Polysomnographic Technologist Form 5

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only

Application for Limited Permit

Applicants Must Complete All Pages of This Application ***In Ink***

Applicant Instructions

1. A limited permit authorizes practice as a polysomnographic technologist under the direction and supervision of a licensed physician and under the direct and immediate supervision of 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. You must meet all requirements for authorization as a polysomnographic technologist **except the licensing examination.** Complete Section I. Be sure to sign and date item 9. It is your responsibility to ensure that the prospective supervisor fully completes Section II.
2. You may apply for a limited permit either at the same time as or after submitting an application for authorization as a polysomnographic technologist in New York State. If you have not yet filed a Application for Authorization (Form 1) and the $600 fee for authorization and first registration, you must submit them with this form and the limited permit fee.
3. Submit this application and the $70 limited permit fee to the Office of the Professions at the address at the end of this form. The limited permit fee is not refundable.
4. **Permits cannot be issued until all required documents have been received and approved. You may not begin practice until a limited permit has been issued.**
5. If you change supervisors or have additional supervisors after a permit is issued, you must obtain a re-issued permit. Complete a new Form 5 with each prospective supervisor, and return it to the Office of the Professions. A new fee is not required for a permit issued as a result of a change in supervisor. Limited permits expire one year from the date of issue and may be renewed for one additional year.

IMPORTANT NOTE: If the physician providing direction and supervision is not also the individual providing direct and immediate supervision, you will need to submit a separate Form 5 for each.

1 | **26** | **$70** | **PR**

Permit Number

Date Issued

Date Expires

Initials

2 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number)

3 **Birth Date** Month Day Year

4 **Print Name**

Last

First

Middle

5 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

6 **Telephone/E-Mail Address**

Daytime phone

Area Code Phone

E-mail Address (please print clearly)

7 **I am applying for**

- ☐ Original permit
- ☐ Additional supervisor/employer
- ☐ Change of supervisor/employer
- ☐ Renewal Permit

8 Name of employer: _____

9 **Attestation**

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of permit and licensure and may result in criminal prosecution.

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

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.