

POLYSOMNOGRAPHY TECHNICIAN/TRAINEE SUPERVISION ATTESTATION FORM

This document is to be filed with the Board of Medicine. A duplicate copy is to be kept on site at the primary place of practice. The name of the supervising physician must be submitted to the Board within thirty (30) days of obtaining said supervisor.

If you have any questions, you may email the Board of Medicine at dcbomed@dc.gov.

SECTION 1: POLYSOMNOGRAPHER

First Name:	MI:	Last Name:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DC Lic. #:

SECTION 2: SUPERVISING PHYSICIAN (if applicable)

First Name:	MI:	Last Name:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DC Lic. #:

SECTION 3: PRACTICE LOCATION(S)

List **ALL** practice locations where the polysomnographer will be providing patient care. Use additional sheets if necessary.

PRACTICE LOCATION #1

Practice Name:		
Practice Address:		
City:	State:	Zip Code:
Department:	Phone #:	

PRACTICE LOCATION #2

Practice Name:		
Practice Address:		
City:	State:	Zip Code:
Department:	Phone #:	

SECTION 4: SIGNATURES

I hereby attest that the information given in this form, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this form, including all writings and exhibits attached hereto, is punishable by criminal penalties.

Furthermore, I attest that I will be supervised by a licensed physician and/or a licensed polysomnographic technologist while acting as a polysomnographic technician/trainee.

SIGNATURE OF POLYSOMNOGRAPHER:	DATE:
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REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at <https://oig.dc.gov>.