To Whom It May Concern:

The person listed below is applying for a license to practice polysomnographic technology in the state of Virginia. The Board of Medicine requests that the form be completed by each jurisdiction in which he/she holds or has held a license/certificate. Please complete the form and return it to the address below. Thank you.

Commonwealth of Virginia
Department of Health Professions
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Name of Applicant (please print or type) ____________________________________________

License/Certificate # ____________________________________________________________________

Name of Licensee ________________________ State/Commonwealth of ______________________________

License/Certification number ________________________ Issued Effective ______________________________

Licensed/Certified Through (check one)

☐ BRPT Examination
☐ NBRC Examination

☐ State Board of Examination
☐ Endorsement from (Name of State) ____________________________________________

License is:  Current ☐ Lapsed ☐

Has the applicant's license/certificate ever been suspended or revoked? ☐ Yes ☐ No

If yes, for what reason?
____________________________________________________________________________________

Derogatory information, if any
____________________________________________________________________________________

Comments, if any
____________________________________________________________________________________

BOARD SEAL
Signed ________________________________

Title ________________________________

State Board ________________________________

NOTE TO APPLICANT: PLEASE PROVIDE LICENSE NUMBER AND FORWARD TO STATE INDICATED