PHOTOGRAPH

Photograph

Affix a 2" X 2" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only

Altered Photographs are NOT Acceptable

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to verify and identify the applicant per Section 118 and 2081 of the California Business and Professions Code. The information on your application may be transferred to other medical licensing authorities or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act.

MBC Use Only

Review PST1A-E

Staff Initials & Date

Photograph ☐

DECLARATION

Applicant Name & DOB ☐

The applicant, _____, _____,
PRINT LEGAL NAME (First, Middle, Last, Suffix) **DATE OF BIRTH (mm/dd/yyyy)**

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; and were procured without fraud or misrepresentation or any mistake of which I am aware. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by the Board in connection with this application; or any further or future investigation by that Board necessary to determine competence, professional conduct, or physical or mental ability to safely engage in the practice of polysomnography. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGN LEGAL NAME:_____DATE:_____

Applicant Signature & Date ☐

NOTARY SECTION

Applicant Signature ☐

SIGNATURE OF APPLICANT: _____
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by, _____ proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

Applicant Name & Notary Date ☐

NOTARY SEAL

Notary Signature & Seal ☐

_____
SIGNATURE OF NOTARY PUBLIC

PST 1E