



Medical Board of California

Polysomnographic Technologist, Technician or Trainee Work Experience Verification

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

MBC USE ONLY

TYPE OF REGISTRATION

I am applying for registration as a (Check One)

☐ Technologist

☐ Technician

☐ Trainee

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
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Applicant
Information
○

Address Of Record

Line 1 (40 characters per line, including spaces)		Line 2 (40 characters per line, including spaces)	
City	State/Province	Zip/Postal Code	Country

○

Telephone Numbers (Include area code)

Primary	Cell	Work
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Phone
○

APPLICANT'S AUTHORIZATION

I am applying for registration as a Polysomnographic Technologist, Technician or Trainee in the State of California. The Medical Board of California requires this form to be completed by the supervising physician. I hereby authorize release of all information in your files, favorable or otherwise.

LEGAL NAME (Print or Type)

SIGNATURE

DATE

○

SUPERVISING PHYSICIAN

The Supervising Physician must complete this section, and page two. An original signature and date is required on the second page. Attach additional pages if necessary to provide tasks performed by the applicant.

Supervising Physician

Name	Phone
License Number	State of Licensure

Applicant
Information
○

Phone
○

Facility Name

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○

Facility Address

Street			
City	State/Province	Zip/Postal Code	Country

○

Form **WEV**

Trainee Work Experience Verification – Page 2 of 2

NOTE: The Supervising Physician must complete this page.

Applicant Name:

EVALUATION OF APPLICANT

Dates of Employment

Beginning Date (month/year)	Ending Date (month/year)
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Dates of
Employment
○

1. In your opinion, is this applicant able to practice polysomnography safely? ☐ Yes ☐ No

If you answered "no" please provide a signed and dated written explanation and any supporting documentation that may be relevant.

VERIFICATION OF EXPERIENCE

Trainee Applicant: In your opinion, is this applicant able to practice polysomnography safely? ☐ Yes ☐ No

Technician Applicant: Has the applicant completed a minimum of six months experience at a level of a polysomnographic trainee? ☐ Yes ☐ No

Verification
of Exp
○

Technologist Applicant: I supervised this applicant for _____ years and _____ months and this applicant ☐ has **or** ☐ has not engaged in the practice of polysomnography safely during that time.

LIST POLYSOMNOGRAPHIC TASKS PERFORMED BY THE APPLICANT BELOW

DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

PRINTED NAME OF SUPERVISING PHYSICIAN

SIGNATURE OF SUPERVISING PHYSICIAN

DATE

Supervising
Physician
Signature &
Date
○