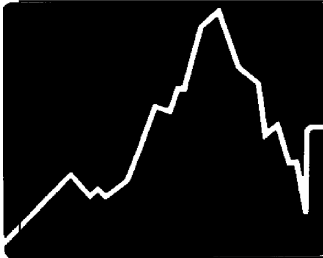


Print Name: _____



**Department of Health Professions
Commonwealth of Virginia**

**Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463**

**Phone(804) 367-4613
FAX (804) 527-4426**

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