



# AMERICAN BOARD OF SLEEP MEDICINE

## SLEEP TECHNOLOGIST REGISTRY EXAMINATION APPLICATION

### PERSONAL INFORMATION

Name:

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Gender:  M  F

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Date of Birth (MM/DD/YYYY):

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Mailing Address:

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Home Telephone:

Work Telephone:

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Email Address:

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(You are responsible for updating the ABSM if your information changes.)

### ELIGIBILITY STATUS

I am currently certified for Basic Cardiac Life Support

(All candidates must be certified - attach copy of unexpired card as *Attachment A*)

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CHOOSE ONE OF THE FOLLOWING ELIGIBILITY PATHWAYS:

- Certificate or Associate's Degree Program (Pathway A)** – Choose **ONE** of the following and attach copy of certificate as *Attachment B*:
  - CoA PSG Program
  - CoA END with PSG Add-on Program
  - CoARC with PSG Add-on Program

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- A-STEP Program (Pathway B)** – Endorse **ALL** of the following and attach evidence of completion as *Attachment B*:
  - High School Diploma
  - Successful completion of an 80-hour A-STEP Introductory Course and A-STEP Modules
  - Successful completion of 50 overnight sleep studies including 20 with continuous positive airway pressure and at least one MSLT within the last 6 months to 3 years (with written verification by a Board Certified Sleep Specialist or Medical Director of an AASM-accredited Sleep Disorders Center)
  - Successful completion of the ABSM sleep scoring proficiency examination (attach certificate) **or** by meeting threshold in the inter-scorer reliability program of an AASM-accredited sleep disorders center for a minimum of 2 months

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- Other Health Professional (Pathway C)** – Endorse **ALL** of the following and attach evidence of completion as *Attachment B*:
  - Health professional credential: \_\_\_\_\_ (acceptable credentials are MD, DO, PhD, PsyD, PA, NP, RN, LPN, CRT, RRT, R.EEG T., R.EP T. or EMT-P)
  - Successful completion of 25 overnight sleep studies including 10 with continuous positive airway pressure and at least one MSLT within the last 3 months to 2 years (with verification by a Board Certified Sleep Specialist or Medical Director of an AASM-accredited Sleep Disorders Center)
  - Successful completion of the inter-scorer reliability requirement either through successful completion of the ABSM sleep scoring proficiency examination (attach certificate) **or** by meeting threshold in the inter-scorer reliability program of an AASM-accredited sleep disorders center for a minimum of 2 months (with written verification by a Board Certified Sleep Specialist or Medical Director of an AASM-accredited Sleep Disorders Center)

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- RPSGT Credential (Pathway D)** – Endorse **ALL** of the following and attach evidence of completion as *Attachment B*:
  - High School Diploma
  - RPSGT credential (attach copy as *Attachment B*)

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**ATTESTATION**

*I hereby declare that I have read and will adhere to the 2012 Examination Handbook.  
I hereby declare that all information contained in this application and all documentation submitted with or in support of the application are true. I understand and agree that any misrepresentation of said facts will result in automatic disqualification to sit for the examination or revocation of the certification obtained.*

Signature: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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**APPLICATION FEE - \$250.00**

Method of Payment (Check one)

**Check** made payable to the AASM (U.S. funds drawn on a U.S. bank)

**Credit Card:**  VISA  MasterCard  American Express

Card # \_\_\_\_\_

Exp. Date: \_\_\_\_\_ Validation Code\*\* : \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*For a VISA or MasterCard, the validation code is the last 3 numbers in the signature box. For an American Express, the validation code is the 4 numbers above the credit card number.

**SEND ALL MATERIALS (THIS APPLICATION, ATTACHMENTS and PAYMENT) TO:**

The American Board of Sleep Medicine  
2510 N. Frontage Road  
Darien, IL 60561-1511  
FAX: 630.737.9790 (credit card payments only)  
E-mail: [absm@absm.org](mailto:absm@absm.org)

# ATTACHMENT B: VERIFICATION OF CLINICAL EXPERIENCE

This form is required for verification of clinical experience and/or inter-scorer reliability requirement by a candidate for an American Board of Sleep Medicine Examination. **A candidate may not verify his or her own experience.**

## CANDIDATE NAME:

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**For candidates applying under the A-STEP pathway (B):** I hereby verify that the above-named candidate has successfully performed a minimum of 50 overnight sleep studies including 20 with continuous positive airway pressure and at least one MSLT

These studies were performed between (MM/DD/YYYY):

\_\_\_\_\_ and \_\_\_\_\_

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**For candidates applying under the Other Health Professional pathway (C):** I hereby verify that the above-named candidate has successfully performed a minimum of 25 overnight sleep studies including 10 with continuous positive airway pressure and at least one MSLT

These studies were performed between (MM/DD/YYYY):

\_\_\_\_\_ and \_\_\_\_\_

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**For A-STEP or Other Health Professional pathways (B or C):** I hereby verify that the above-named candidate has successfully completed 2 or 3 months of an inter-scorer reliability program meeting threshold for agreement with a gold standard scorer as defined by AASM Accreditation Standard F-9

The inter-scorer reliability program was performed between (MM/DD/YYYY):

\_\_\_\_\_ and \_\_\_\_\_

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### **Certifying Individual:**

I am a Board Certified Sleep Specialist or Medical Director of an AASM-accredited sleep disorders center and I hereby certify that I have personal knowledge that this candidate has completed the clinical experience and/or inter-scorer reliability requirements as indicated above.

<b>Printed Name and Degree:</b>
<b>Signature:</b> _____ <b>Date:</b> _____
<b>ABSM/ABMS Certificate or AASM-accredited Sleep Center Number:</b>