AMERICAN BOARD OF SLEEP MEDICINE

SLEEP TECHNOLOGIST REGISTRY RECERTIFICATION APPLICATION

PLEASE NOTE: Applications can be submitted on January 1 of the year your credential expires and must be submitted by the date your certification expires.

PERSONAL INFORMATION

Name: _____

RST#*:_____ RST Date Earned*: _____

Mailing Address: _____

City:_____ State: _____ Zip Code: _____

Cell or Home Telephone: _____ Work Telephone:_____

Email Address: _____

Please ensure that the ABSM is notified if any of the above changes.
*This information is available at http://absm.org/rstlist.aspx.

ELIGIBILITY STATUS

◯ I am currently certified in Basic Life Support for Healthcare Providers
(All candidates must be certified – attach a copy of unexpired card)

◯ I have uploaded certificates showing at least 50 sleep-related continuing education credits earned in the past five years to the ABSM credit-tracking site http://absm.org/registrationselect.aspx.

◯ I intend to take the RST recertification examination prior to my certification expiring. Please send me instructions for registering for the exam.

ATTESTATION

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 that the ABSM conducts random audits as part of the recredentialing process. I understand and agree that any misrepresentation of said facts will result in revocation of the credential obtained.

Signature: _____ Date: _____

FEE SCHEDULE

◯ **Recertification Fee** **$50.00**

◯ **RST Exam** **$175.00**
(Required if you did not provide proof of 50 continuing education credits)

◯ **One-time 90-Day Extension Fee** **$50.00**
(The 90-Day Extension is only applicable during the 90 days after the expiration of your RST Certification. Applicants must be recertified within the 90-day period to avoid suspension.)

TOTAL $ _____

Method of Payment *(Check one)*

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

◯ **Credit Card**: ◯ Visa ◯ MasterCard ◯ American Express ◯ Discover

Card #: _____

Expiration Date: _____ Validation Code**: _____

Cardholder's Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

By signing, you authorize the ABSM to charge your credit card for the above fees.

**For Visa, MasterCard, or Discover, 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:

Mail: The American Board of Sleep Medicine
2510 North Frontage Road
Darien, IL 60561-1511

Fax: (630) 737-9790 *(credit card payments only)*