

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:

- 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 _____

- 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 _____

- For candidates applying under the On-the-Job Training pathway (E): I hereby verify that the above-named candidate has been employed by the sleep facility for at least one year and is competent in the areas shown on the 80-hour didactic Accredited Sleep Technology Education Program (A-STEP) Introductory Program ([sample syllabus](#))

- The candidate has been employed at the sleep facility since (MM/DD/YYYY):

_____ and _____

- For A-STEP, Other Health Professional pathways, or On-the-Job Training Pathways (B, C, or E): I hereby verify that the above-named candidate has successfully completed 3 months of an inter-scorer reliability program meeting threshold for agreement with a gold standard scorer as defined by AASM Accreditation Standard F-7

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

_____ and _____

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 requirements as indicated above.

Printed Name:

Degree:

Signature: _____

Date:

ABSM/ABMS Certificate or AASM-accredited Sleep Center Number: