



# Pulmonary Medicine Associates Sleep Disorder Center

601 S. Arlington Avenue Reno, NV 89509 (775)329-1727

**A•STEP**

**Accredited Sleep Technologist Education Program**

## Enrollment Application

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Email: \_\_\_\_\_



Education: Please indicate years completed and degrees earned.

	High School				College/University				Graduate/Professional			
Years Completed	9	10	11	12	1	2	3	4	1	2	3	4
Diploma/Degree												
Course of Study												

Polysomnography Experience:      Y      N      Years: \_\_\_\_\_ Months: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

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

Employer Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Website: \_\_\_\_\_

**Payment Method:** Please check appropriate box and provide the information requested.

Cash       Check       Please make checks payable to Payable to Pulmonary Medicine Associates.

Visa       Master Card       Name of card holder: \_\_\_\_\_

Credit Card number: \_\_\_\_\_ Security ID: \_\_\_\_\_ Exp Date: \_\_\_\_\_  
(3 digits on back of card)