FOR OFFICE USE ONLY
Respiratory Care Checklist
☐ Endorsement ☐ Examination
☐ Temporary ☐ Graduate
☐ App. & Fee
☐ Date:_____ Check_____
☐ Transcript
☐ Score/Certification from NBRC
☐ Lic. Verification from other States

FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Grad/Temp Lic. #:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

Rhode Island
Board of Respiratory Care

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License As A

Respiratory Care Practitioner

License #_____

Name_____

☐ **Endorsement**

Temporary Status ☐ **Yes** ☐ **No**

☐ **Examination**

Graduate Status ☐ **Yes** ☐ **No**

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

☐ I am in active military duty or a reservist
☐ I am a military veteran with honorable discharge
☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	*FIRST NAME*	*MI*

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 10/30/2018 jcp

LICENSURE REQUIREMENTS

☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are re-ceived at RIDOH. If you are not licensed within the year you must submit a new application.

☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$60.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.

☐ Official transcript from an accredited School of Respiratory Care submitted by the college/school/university, directly to the Board. Transcript must include date of completion, graduation date and degree.No student copies will be accepted. If you are a new graduate and applying for Graduate Status and your transcript is not yet available, a certified statement may be **sent directly FROM** the Dean or Registrar of the Respiratory Care School verifying your completion of **ALL GRADUATION REQUIREMENTS**, A completed official transcript must be **sent directly FROM the school** to the Board of Respiratory Care as soon as it is available. A license cannot be issued without receipt of an official transcript.

☐ Score/Certification sent directly from the National Board of Respiratory Care (NBRC) **(Telephone 1-913-599-4200)** to the Board of Respiratory Care.

☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)

☐ If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

☐ ***Graduate Status***

Requirements listed above with the exception of scores from NBRC.

Application for graduate status must be filed within 30 days of date of graduation. Graduate status permits are issued for a period of 90 days and may not be renewed. **Failure to pass the certification examination results in the revocation of a graduate status permit**.

☐ ***Temporary Status***

Applicants who provide documentation of current licensure in another state, and who file an application with the above fee, may receive a temporary license to practice, under supervision of a licensed respiratory care practitioner, until he/she is fully licensed by completing the above license requirements.

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the ex pense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

State of Rhode Island
Board of Respiratory Care
Application for License as a Respiratory Care Practitioner

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year 19

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated: Month Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I _____ being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Respiratory Care Practitioner in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Respiratory Care of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Board of Respiratory Care
Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Respiratory Care Practitioner in the State of Rhode Island. The Rhode Island Board of Respiratory Care requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Respiratory Care at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number

Date of Birth 19

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE RESPIRATORY CARE BOARD

Respiratory Care Program Completed:	Location:	Graduation Date:

Licensed by Examination? ☐ Yes ☐ No

Applicant has completed and passed the National Certification Exam: ☐ Yes ☐ No

License Status:	Original Date Issued:	Expiration Date:
☐ Active ☐ Inactive ☐ Lapsed		

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name

Title

Full Name of Licensing Board

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.