INSTRUCTIONS FOR COMPLETING A RESPIRATORY THERAPIST APPLICATION

(This form has been designed to be used as a checklist for submitted required documentation.)

☐ **Application and Fee –** The completed four (4) page application should be returned with the required fee of $130.00. Applications **will not** be processed unless the fee is attached. Applications submitted without the application fee will be returned. Checks should be made payable to the "Treasurer of Virginia". This document **may not** be faxed.

☐ **Claims History -** if you answered yes to question #14 on page three of the application please include a separate page detailing your claims history to include your care and treatment of the patient involved as well as the outcome of the claim.

☐ **Employment Activity Questionnaire (Form B) -** Forward form B to all places of employment listed on the chronological page of your application for the last 5 years. This form may be copied as necessary**.** This documentation **may** be faxed. This form may not apply to new graduates.

☐ **Jurisdiction Clearance** – Verification from all jurisdictions in which you have been issued a license, certification or registration must be received by the Board. Please contact the applicable jurisdictions to inquire about processing fees. Verifications may be faxed directly from the jurisdiction.

☐ **Certification of Credentials from NBRC:** Certification should be requested from the NBRC, this documentation **may not** be faxed:

National Board of Respiratory Care, Inc.
18000 W. 105th Street
Olathe, KS 66061
(913)599-4200

Please note:

*Please be aware that consistent with Virginia law and the mission of the Department of Health Professions, addresses on file with the Board of Medicine are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, with the application of new technology, which makes this information more accessible, there has been growing concern of those licensees who supply their residence address for mailing purposes. This notice is to reiterate that the Board of Medicine maintains only one address for each licensee and will allow the address of record to be a Post Office Box or practice location.

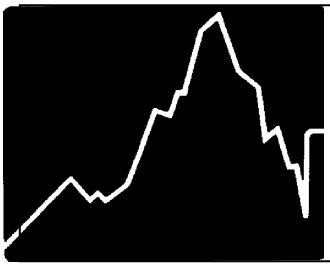
*Applications not completed within 6 months may be purged without notice from the board.

*Additional information may be requested after review by board representatives.

Application fees are **non-refundable.*

* Contact: medbd@dhp.virginia.gov Fax#: 804-527-4426

Rev. 08/15 RESPIRATORY CARE PRACTITIONER



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300 **(804) 367-4613**
Henrico, VA 23233-1463

Application for a License to Practice as a Respiratory Therapist

I hereby make application for a license to practice Respiratory Therapy in the Commonwealth of Virginia and submit the following statements:

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH IN THIS SPACE.

Last	First	Middle
Street Address	**City/State**	**Zip Code**

Date of Birth	Place of Birth	Social Security/VA Control #	Maiden Name if Applicable
_____/_____/_____			

Professional School Name & Location	Professional School Graduation Date	Professional School Degree
	_____/_____/_____	

Please accompany with this application a check or money order made payable to the Treasurer of Virginia in the required amount. If the money does not accompany the application, the application **will** be returned. Please submit address changes in writing immediately.

*In accordance with §54.1-116 in the **Code of Virginia**, you are required to submit your Social Security number/Control number (issued by the Virginia Department of Motor Vehicles.). This number will be used by the Department of Health Professions for identification purposes only and will not be disclosed for any other purposes except as mandated by law. Federal and State law requires that this number be shared with other state agencies for child support enforcement activities. **Failure to disclose this number will result in the denial of a license to practice in the Commonwealth of Virginia.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY: _____

Applicant #	Check #	Class #	Fee
		0117	**$130.00**

1. List in chronological order all professional practices since graduation, including internships, residencies, hospital affiliations and absences from work. Also list all periods of non-professional activity or employment for more than three months. **PLEASE ACCOUNT FOR ALL TIME.** If engaged in private practice, list all hospital affiliations. If none, please explain. A completed Form B must be received for all places listed for the **last five years**.

From	To	Name & Location	Position Held
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2. Please provide a telephone number where you can be reached during the day. This information is not mandatory and if provided will not be used for any purpose other than as a contact if the licensing specialist has questions about your application.

Home #:	Work #:	Email Address:

These questions must be answered in order for your application to be considered complete. If any of the following questions (#7-16) is answered yes, please provide supporting documentation. Letters must be submitted by your attorney regarding malpractice suits (or you may complete and submit Form A yourself.)

3. I hereby certify that I studied respiratory therapy and received the degree of _____ on _____
(degree) (date)
from _____.
Name of School

4. Do you intend to engage in the active practice of respiratory therapy in the Commonwealth of Virginia? ☐Yes ☐No

5. Specify type of practice: ☐ Hospital; ☐ Home Care; ☐ Education; ☐ Research; ☐ Other, specify _____

6. List all jurisdictions in which you have been issued a license to practice respiratory therapy. Include the number and date issued of all active, inactive or expired licenses.

Jurisdiction	Number Issued	Active/Inactive/Expired

7. Have you ever been denied the privilege of taking a Respiratory Therapy examination? ☐Yes ☐No

8. Have you ever taken an NBRC, Inc. Credentialing examination? If so, what professional credentials do you presently hold with the NBRC, Inc.? _____ ☐Yes ☐No

9. Have you ever been denied a certificate/license or the privilege of taking an examination before any state, territory, or country? ☐Yes ☐No

10. Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state or local statute been censured or warned, or requested to withdraw from the staff of any professional school, training program, hospital, nursing home, or other health care facility, or health care provider? ☐Yes ☐No

11. Have you ever been denied privileges or voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or requested to withdraw from the staff of any professional school, internship, hospital, nursing home, or other health care facility, or health care provider? ☐Yes ☐No

12. Have you ever had any of the following disciplinary actions taken against your certificate/license to practice Respiratory Therapy or are any such actions pending? (a) suspension/revocation; (b) probation; Reprimand/cease and desist; (d) had your practice monitored ☐Yes ☐No

13. Have you ever had any membership in a state of local profession society revoked, suspended or sanctioned? ☐Yes ☐No

14. Have you had any malpractice suits brought against you in the last ten (10) years? If so, how many? _____ ☐Yes ☐No
If you have answered yes, please fill out Form A.

15. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two years? If so, please provide a letter from the treating professional. ☐Yes ☐No

16. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties? If so, provide a letter from your treating professional to include diagnosis, treatment, prognosis and fitness to practice. ☐Yes ☐No

(THIS SECTION MUST BE NOTARIZED)

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

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities(local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information , which is material to me and my application.

I have carefully read 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 the denial, suspension, or revocation of my license to practice respiratory care in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available on www.dhp.virginia.gov, and I fully understand that funds submitted as part of the application process shall not be refunded.

_____

Signature of Applicant