



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
APPLICATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER

MISSOURI BOARD FOR RESPIRATORY CARE
 P.O. BOX 1335
 JEFFERSON CITY, MO 65102-1335
 TELEPHONE: (573) 522-5864
 WEBSITE: pr.mo.gov
FOR DELIVERY:
 3605 MISSOURI BOULEVARD
 JEFFERSON CITY, MO 65109

PLEASE REFER TO DETAILED INSTRUCTIONS ON THE ENCLOSED SHEET

1. This form must be typed or printed legibly in black ink.
2. If you do not provide complete information and all required documents **as detailed on the enclosed instruction sheet**, your application will not be processed.
3. Attach a recent 2" x 2" head and shoulders photograph of yourself in the space provided to the right.
4. Fingerprints must be obtained from a law enforcement agency.
5. Enclose your check or money order for the application fee of **\$40.00** made payable to **MISSOURI BOARD FOR RESPIRATORY CARE**.
6. Sign your application in the presence of a notary public and have your signature notarized.
7. Request verification of your credentials from the National Board for Respiratory Care (NBRC) be sent directly to the Missouri Board for Respiratory Care.
8. Request verification of licensure from other states, territories, or countries (see instructions).
9. Pursuant to § 620.127, RSMo, disclosure of your social security number (SSN) is mandatory. The board will not publicly disclose your SSN without your consent, unless such disclosure is permitted by federal or state law. However, state law allows the board to disclose your SSN in connection with any civil, criminal, administrative or arbitral proceeding, in an investigation in anticipation of litigation, pursuant to a court order, and in the performance of a statutory or constitutional duty or power. The board can also disclose your SSN to another government agency (federal, state or local) and to a private person or entity acting on behalf of, or in cooperation with, a state entity. State law requires the board to provide your SSN to child support and tax compliance officials.
10. **Fees are non-refundable.**
11. **This application will expire if the process is not completed within six (6) months from the date it is received in the Board office.**

AFFIX
 PHOTOGRAPH
 HERE

APPLICANT DATA

FIRST NAME	MIDDLE NAME	LAST NAME	MAIDEN NAME	
SOCIAL SECURITY NUMBER	E-MAIL	DATE OF BIRTH	RESIDENCE TELEPHONE NUMBER	
RACE (THIS INFORMATION IS VOLUNTARY)		GENDER (THIS INFORMATION IS VOLUNTARY)		
RESIDENCE STREET ADDRESS (IF PO BOX, PLEASE ALSO PROVIDE A STREET ADDRESS)		CITY	STATE	ZIP
CURRENT PLACE OF EMPLOYMENT			EMPLOYMENT TELEPHONE NUMBER	
EMPLOYMENT ADDRESS		CITY	STATE	ZIP

EDUCATION (Also include any military medical training) (If additional space is needed please attach sheets as necessary.)

COLLEGE, UNIVERSITY OR PROFESSIONAL SCHOOL	CITY/STATE	DATES ATTENDED				DEGREE OR CERTIFICATE AWARDED/ DATE	MAJOR COURSE OF STUDY
		FROM		TO			
		MON.	YR.	MON.	YR.		

NATIONAL CREDENTIALS

I HOLD THE FOLLOWING CREDENTIAL(S) ISSUED BY THE NATIONAL BOARD FOR RESPIRATORY CARE (NBRC)

CERTIFIED RESPIRATORY THERAPY TECHNICIAN, (CRTT), ISSUE DATE: _____

REGISTERED RESPIRATORY THERAPIST, (RRT), REGISTRY NUMBER: _____

HAVE YOUR CREDENTIALS EVER BEEN DISCIPLINED, SANCTIONED, SUSPENDED OR REVOKED? IF YES, EXPLAIN ON A SEPARATE SHEET.

YES NO

LICENSURE, CERTIFICATION OR REGISTRATION**YES NO**

The applicant must answer the following questions. If any of the questions are answered yes, the applicant must provide a notarized explanation.

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Have you ever been issued a professional license, certification, registration, or permit in the field of respiratory care by any state, United States territory, province or country? If yes, please list the state, territory, province or country, type of license with license number, status of license, and your name as it appears on the license. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been denied a professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? If yes, explain fully in a separate notarized statement. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold? If yes, explain fully in a separate notarized statement. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime whether or not sentence was imposed, or are such actions currently pending (excluding traffic violations)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs, alcohol, whether or not sentence was imposed, or are such actions currently pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you currently, or did you within the past five years, use any prescription drug, controlled substance, illegal chemical substance, or alcohol, to the point where your ability to competently practice as a respiratory care practitioner would be affected? If yes, explain fully in a separate notarized statement. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program? If yes, explain fully in a separate notarized statement and attach verification of chemical or alcohol dependency treatment. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception or malpractice related to your practice as a respiratory care practitioner? If yes, explain fully in a separate notarized statement and attach certified copies of court documents. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a medical condition that in any way impairs or limits your ability to perform with reasonable care and safety the essential functions of a respiratory care practitioner with or without reasonable accommodations? If yes, explain fully in a separate notarized statement. | <input type="checkbox"/> | <input type="checkbox"/> |

RESPIRATORY CARE EXPERIENCE - LIST ALL EMPLOYERS IN THE LAST FIVE YEARS

BEGIN WITH THE MOST RECENT EMPLOYMENT, USING ADDITIONAL SHEETS IF NECESSARY

A. NAME OF EMPLOYER

ADDRESS OF EMPLOYER

FROM		TO		NAME OF IMMEDIATE SUPERVISOR
MON.	YR.	MON.	YR.	
				TITLE OF APPLICANT'S POSITION

B. NAME OF EMPLOYER

ADDRESS OF EMPLOYER

FROM		TO		NAME OF IMMEDIATE SUPERVISOR
MON.	YR.	MON.	YR.	
				TITLE OF APPLICANT'S POSITION

C. NAME OF EMPLOYER

ADDRESS OF EMPLOYER

FROM		TO		NAME OF IMMEDIATE SUPERVISOR
MON.	YR.	MON.	YR.	
				TITLE OF APPLICANT'S POSITION

Pursuant to Section 324.010 RSMo:

CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

SWORN AFFIDAVIT

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a license to practice respiratory care in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit in consideration this application as required by the Missouri law governing the practice of respiratory care and subject to the rules and regulations of the Missouri Board for Respiratory Care. I subscribe and agree to abide by all applicable laws and rules regarding the practice of respiratory care. I hereby certify that I have familiarized myself with sections 334.800-334.930 RSMo, known as the Respiratory Care Practice Act and applicable rules promulgated by the Missouri Board for Respiratory Care.

Enclosed is the application fee which is not refundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	SIGNATURE OF APPLICANT		
	STATE OF	COUNTY	
	SUBSCRIBED AND SWORN BEFORE ME, THIS		USE RUBBER STAMP IN CLEAR AREA BELOW.
	DAY OF	YEAR	
NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES		
NOTARY PUBLIC NAME (TYPED OR PRINTED)			