MISSOURI BOARD FOR RESPIRATORY CARE
P.O. BOX 1335
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65102-1335
TELEPHONE: (573) 522-5864
TDD (800) 735-2966
Web: pr.mo.gov

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

VERIFICATION OF EDUCATION

INSTRUCTIONS

Complete Section I and provide this form to your educator, program director or director of clinical education. This verification form must be returned to the Missouri Board for Respiratory Care by the educational program. This form may be photocopied as necessary.

SECTION I - TO BE COMPLETED BY APPLICANT

NAME FIRST	MIDDLE	LAST	SUFFIX	MAIDEN	OTHER NAMES THAT YOU HAVE BEEN KNOWN AS

SOCIAL SECURITY NUMBER	DATE OF BIRTH	NAME OF INSTITUTION	NAME OF PROGRAM

The Missouri Board for Respiratory Care requests that I submit evidence of enrollment in an accredited respiratory care education program. I hereby authorize _____ (NAME OF INSTITUTION) to release any information pertaining to me, favorable or otherwise, directly to the Missouri Board for Respiratory Care, P.O. Box 1335, Jefferson City, MO 65102.

I understand that if I wish to provide respiratory care services outside the educational program, I may only provide such services under the direct clinical supervision of a licensed respiratory care practitioner approved by the Missouri Board for Respiratory Care. If, for any reason, the arrangements for my supervision should change, I will notify the Missouri Board for Respiratory Care immediately.

APPLICANT SIGNATURE	DATE

SECTION II - THIS SECTION MUST BE COMPLETED BY AN EDUCATOR OF THE INSTITUTION FROM WHICH THE APPLICANT IS ENROLLED. THE SEAL OF THE INSTITUTION MUST BE IMPRESSED ON THIS FORM, OR THE STATEMENT AT THE BOTTOM OF THIS FORM MUST BE SIGNED BY THE AUTHOR OF THIS SECTION AND THE SIGNATURE NOTARIZED. ALL SIGNATURES MUST BE ORIGINAL.

I, _____ (NAME) , do hereby certify that _____ (NAME OF APPLICANT) :

☐ is currently enrolled in _____ (INSTITUTION NAME) in the _____ (NAME OF PROGRAM) located in _____ (INSTITUTION CITY AND STATE) and that _____ (NAME OF INSTITUTION) is an accredited respiratory care education program. Expected graduation date _____ .

☐ has graduated from _____ (NAME OF INSTITUTION) located in _____ (INSTITUTION CITY AND STATE) and that _____ (NAME OF INSTITUTION) is an accredited respiratory care program. Date of graduation _____ . Type of degree/diploma/certificate awarded _____

☐ is no longer enrolled as a student of _____ (NAME OF INSTITUTION) located in _____ (INSTITUTION CITY AND STATE)

The Records of this institution indicate that while enrolled the applicant ☐ was ☐ was not the subject of disciplinary action during clinical education.

SIGNATURE	DATE	PLEASE AFFIX SCHOOL SEAL
NAME PRINTED	TITLE	

NOTE: THE INSTITUTION HAS NO SEAL ☐

SIGNATURE

NOTARY PUBLIC EMBOSSER SEAL	STATE OF		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		