

Regular Mailing Address  
State Board of Medicine  
State Board of Osteopathic Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

Courier Delivery Address  
State Board of Medicine  
State Board of Osteopathic Medicine  
2601 North Third Street  
Harrisburg, PA 17110

Medical Board 717-787-2381 [st-medicine@state.pa.us](mailto:st-medicine@state.pa.us)  
Osteopathic Board 717-783-4858 [st-osteopathic@state.pa.us](mailto:st-osteopathic@state.pa.us)

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## APPLICATION FOR CERTIFICATION AS A RESPIRATORY CARE PRACTITIONER

This application can be used for certification under the State Board of Medicine or State Board of Osteopathic Medicine. You must choose under which Board you wish to be certified. Certification by either Board permits you to provide respiratory care services by direction of either a medical doctor or doctor of osteopathic medicine.

If documents will be submitted to the Board under a name different than your present name, submit a copy of the legal document evidencing the name change. I.E., marriage license, divorce decree, naturalization, etc.

### INSTRUCTIONS FOR APPLICANTS WHO HOLD NBRC CERTIFICATION:

- The total fee required is \$30. Check/money orders should be made payable to the Commonwealth of PA.
- Complete the Verification of Education (Page 3) and send to the respiratory care program where you graduated. **The program must send the completed form directly to the Board office in an official school envelope.**
- Contact the NBRC at 8310 Nieman Road, Lenexa, KS 66214 or by phone at (913) 599-4200 and arrange for your exam scores to be sent directly to the Board in an official envelope.
- Request letters of good standing from every state licensing Board where you have ever held a license/certificate to practice respiratory care. **Letters must come directly from the licensing agency to the Board office.**
- Attach a curriculum vitae listing all periods of employment or unemployment (i.e, child rearing, research, etc.) from graduation from the respiratory care program to date. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.

### TEMPORARY PERMIT APPLICANTS:

- The total fee required for a temporary permit and certification is \$60. Check/money orders should be made payable to the Commonwealth of PA.
- Temporary permits will expire within 12 months of issuance or upon failure of the NBRC exam, whichever occurs first.
- THE respiratory care practitioner examination application can be downloaded or filed online through the NBRC's website at [www.nbrc.org](http://www.nbrc.org).

THE FOLLOWING APPLICANT'S ARE ELIGIBLE FOR A TEMPORARY PERMIT.  
Instructions are listed under each eligibility method.

- Graduate of a CoARC accredited respiratory care program and waiting to take or waiting for the results of the NBRC's CRTT Exam
  - Complete the Verification of Education (Page 3) and send to the respiratory care program where you graduated. **The program must send the completed form directly to the Board office in an official school envelope.**
  - Contact the NBRC at 8310 Nieman Road, Lenexa, KS 66214 or by phone at (913) 599-4200 and arrange for your exam scores to be sent directly to the Board in an official envelope.
  - Request letters of good standing from every state licensing board where you have ever held a license/certificate to practice respiratory care. **The licensing agency must send the letter directly to the Board office.**
  - Attach a curriculum vitae listing all periods of employment or unemployment (i.e., child rearing, research, etc.) from graduation from the respiratory care program to date. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
  
- Expected to graduate within 30 days from a CoARC accredited respiratory care program and scheduled to take the next CRTT exam given by the NBRC
  - Complete the Verification of Education (Page 3) and send to the respiratory care program where you will graduate. **The program must send the completed form directly to the Board office in an official school envelope.** The form may not be completed and submitted more than 30 days prior to graduation.
  - After taking the exam, contact the NBRC at 8310 Nieman Road, Lenexa, KS 66214 or by phone at (913) 599-4200 and arrange for your exam scores to be sent directly to the Board in an official envelope. When the Board receives your passing exam scores, your temporary permit will automatically be transferred to a certification.
  
- Grandfather Clause for providing respiratory care services for at least 12 consecutive months immediately preceding December 28, 1993.
  - The Department Head/Employer must complete and sign the Affidavit of Employment (Page 4). Attach a copy of your current job description with this employer.
  - If determined to be eligible, you will be issued a temporary permit. **UPON RECEIPT OF THE TEMPORARY PERMIT, YOU MUST APPLY TO SIT FOR THE NEXT AVAILABLE NBRC EXAM.** An application for examination can be obtain from the NBRC at [www.nbrc.org](http://www.nbrc.org).
  - After taking the exam, contact the NBRC at 8310 Nieman Road, Lenexa, KS 66214 or by phone at (913) 599-4200 and arrange for your exam scores to be sent directly to the Board in an official envelope. When the Board receives your passing exam scores, your temporary permit will automatically be transferred to a certification.

STATE BOARD OF MEDICINE OR  
STATE BOARD OF OSTEOPATHIC MEDICINE  
P.O. Box 2649  
Harrisburg, PA 17105-2649

### APPLICATION FOR CERTIFICATION AS A RESPIRATORY CARE PRACTITIONER

Check the Board under which you are applying to be certified.

- State Board of Medicine
- State Board of Osteopathic Medicine

- Check to indicate that you desire a temporary permit (Temporary permits are only available to new graduates or grandfather applicants). **A temporary permit is valid for 1 year from date of issuance or upon failure of the examination, whichever occurs first.**

FEE: Temporary permit and certification-attach a \$60 fee. Certification without a temporary permit-attach a \$30 fee. Check/money orders should be made payable to the Commonwealth of PA. **Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason of non-payment.**

NAME \_\_\_\_\_  
LAST FIRST MIDDLE MAIDEN

ADDRESS \_\_\_\_\_  
STREET

\_\_\_\_\_ CITY STATE ZIP CODE

EMAIL ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**If supporting documents are listed under another name or names, list below:**

\_\_\_\_\_

NAME AND ADDRESS OF RESPIRATORY THERAPY SCHOOL \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE OF GRADUATION \_\_\_\_\_

If you answer **"YES"** to questions 2-6, you must provide complete details on a separate 8 1/2 x 11 sheet as well as certified copies of relevant documents.

	YES	NO
1) Do you hold or have you ever held a license, certification, or registration (active or inactive, current or expired) to practice in any other jurisdiction? <b><u>If yes, list the jurisdiction below.</u></b>		
2) Has any disciplinary action been taken against your license or certificate in another state, territory or country?		
3) Have you ever withdrawn an application for a license, had an application denied or refused, or agreed not to reapply for a license in another state, territory or country? A license includes a registration or certification.		
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		
5) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?		
6) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Impaired Professional Program.)		

### VERIFICATION

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine/State Board of Osteopathic Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of the certificate.

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SIGNATURE OF APPLICANT

DATE

## VERIFICATION OF RESPIRATORY THERAPY EDUCATION

Section 1 - **Applicant** - Complete Section 1 and send to your respiratory therapy school for completion of Section 2.

**NAME:** \_\_\_\_\_  
Last First Middle

**NAME of Institution:** \_\_\_\_\_

**Location:** \_\_\_\_\_

Section 2 - **Dean/Registrar of respiratory therapy school** - Complete bottom portion and return in an official school envelope directly to the State Board. This form may not be completed and submitted more than 30 days prior to graduation.

Name of student: \_\_\_\_\_

Date student began to attend this school: \_\_\_\_\_  
Month/Day/Year

Date of graduation/expected date of graduation: \_\_\_\_\_  
Month/Day/Year

\_\_\_\_\_  
Program Director's Signature

(SCHOOL SEAL)

\_\_\_\_\_  
Institution Name CoARC School Ref #

\_\_\_\_\_  
Date

## AFFIDAVIT OF EMPLOYMENT FOR GRANDFATHER APPLICANTS

SECTION 1 - **Applicant** - Complete Section 1 and attach a current job description.

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**EMPLOYED BY:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**DATES OF EMPLOYMENT:** From \_\_\_\_\_ To \_\_\_\_\_

SECTION 2 -**Supervisor** - Complete Section 2.

I certify that \_\_\_\_\_ has  
Name of Applicant

provided respiratory care services for at least 12 consecutive months

immediately preceding December 28, 1993. I further certify the dates of

of services as a respiratory care practitioner for the above individual are:

**From** \_\_\_\_\_ **To** \_\_\_\_\_  
Month Day Year Month Day Year

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/Title