BOARD OF RESPIRATORY CARE

APPLICATION MATERIALS FOR REGISTERED RESPIRATORY THERAPIST & CERTIFIED RESPIRATORY THERAPIST LICENSURE

July 2012 Edition

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

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Website: www.flhealthsource.com

Board of Respiratory Care

Mailing address for application & fees:
Board of Respiratory Care
P.O. Box 6330
Tallahassee, FL 32314-6330
Phone: (850) 245-4373 ~ Fax (850) 414-6860
Website: www.flhealthsource.com

(CLIENT 5701 REGISTERED RESPIRATORY THERAPIST - RT)
(CLIENT 5702 CERTIFIED RESPIRATORY THERAPIST – TT)

1. APPLICATION BY ENDORSEMENT and FEE (Please Type or Print Legibly in Blue or Black Ink) - Money order or check, certified or cashier preferred, payable to: The Department of Health.

(Certified/Registered with NBRC and passed the NBRC exam) (Must check one):

☐ **Certified Respiratory Therapist** (Client 5702) - **$165**
☐ **Registered Respiratory Therapist** (Client 5701) **- $165**

2. PROFILE INFORMATION (List your full, legal name as it should appear on license, no nicknames or shortened versions.)

NAME: Last_____ First _____Middle _____

List all names by which you are currently known or have been known in the past. _____

MAILING ADDRESS_____
IMPORTANT: Postal Service does not forward Government mail. You must keep address updated during licensure process to avoid delay. **If you use a P.O. Box address as a mailing address we must also have a physical address**.

Apt. No. _____ City_____ State_____ Zip_____ Country_____

PRACTICE ADDRESS (If not applicable indicate with N/A) _____

Apt. No. _____ City_____ State_____ Zip_____ Country_____
Mailing address will display on the Internet if you have not provided a practice location address.

DATE OF BIRTH (m/d/yr)	
WORK NUMBER: _____	**CORRESPONDENCE VIA E-MAIL?** ☐ **YES** ☐ **NO**
HOME NUMBER: _____	**E-MAIL ADDRESS:**
CELL NUMBER: _____	_____@_____
FAX NUMBER: _____	Please print legibly. By checking "yes" you agree to allow the board office to contact you with information regarding your application via e-mail.

3. RT SCHOOL OF GRADUATION (Name/State/Country): _____**(Must list school)**
Do not leave blank.

Date of Graduation (m/d/y): _____**Degree Obtained:** _____

What name(s) did you use when you received your respiratory therapy education? _____

4. EQUAL OPPORTUNITY DATA - We are required to ask that you furnish the following information as part of your voluntary compliance with Section 60-3, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38295 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure. **SEX:** ☐ Male ☐ Female

ARE YOU A US CITIZEN? ☐YES ☐NO

ETHNIC ORGIN: ☐ White ☐ Black ☐ Asian/Pacific ☐Hispanic ☐Other _____

5. APPLICANT BACKGROUND Attach additional sheets, if necessary.

A. Are you credentialed as a Certified Respiratory Therapist or Registered Respiratory Therapist by the National Board of Respiratory Care? ☐ Yes ☐ No If "YES", give the date of credentialing. _____

B. Do you now hold, or have you ever held, a temporary permit, a license/certification or been authorized to practice in any state, including Florida, or country as a respiratory therapist? (including, but not limited to active and inactive licenses)? ☐ Yes ☐ No

State/Country	License No.	Profession	Date of Licensure	If no longer licensed, state why & when

C. Have you ever previously applied for licensure in the state of Florida? ☐ Yes ☐ No
Date_____

If "YES", did you apply by exam or endorsement? _____

Were you issued a temporary permit? ☐ Yes ☐ No

6. PRACTICE EMPLOYMENT Attach additional sheets, if necessary.

List in chronological order all respiratory related employment **in any state including Florida** for the previous two (2) year period, beginning with present employment. **IF YOU HAVE NOT HAD PREVIOUS RESPIRATORY RELATED EMPLOYMENT in any state including Florida JUST WRITE "not applicable" or N/A.** Do not include clinical/fieldwork experience obtained as part of your education. DO NOT LEAVE BLANK. Respiratory related employment is not a requirement for licensure.

Please review Rule 64B32-2.001(3)(d), F.A.C., for additional requirements. An applicant who has been out of the practice of respiratory care for 2 years or more must complete a Board-approved comprehensive review course in order to ensure that he or she has the sufficient skills to re-enter the profession. (Refer to rule or application instructions for topics and hours.)

Name and Address of Institution	Beginning/Ending Dates of Practice	Title of Position

Answer questions in sections 7 through 9 “Yes","No" or “N/A” - Do not leave any blanks**. You may be required to make a personal appearance before the Board of Respiratory Care. A “YES" answer to sections 7 through 9 must be accompanied by the following:**

1. A written statement explaining in detail the circumstances surrounding the "YES" answer. The statement must include all pertinent information such as date(s), explanation(s), address(es), employer(s), physician(s), institution(s), agency(ies) and hospital(s). Give a brief summary in the space given below and attach any statements to the application, numbering your response according to the number of the question for which you are attaching the statement.

2. Supporting documentation must also be submitted to verify the events, including court documents for <u>each offense</u>, providing arrest records, restitution or current circumstances, final disposition, etc. If the records are no longer available, you must have certification of their unavailability from the court.

<u>Please see application instructions (Competing the Application) for additional information regarding “yes” answers on this page.</u>

7. CRIMINAL HISTORY Attach additional sheets, if necessary.

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if the court withheld adjudication so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for the purposes of this question.

☐ Yes ☐ No

If “YES”, explain _____

Note: Pursuant to Section 456.0635, Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

8. CRIMINAL HISTORY CONTINUED

8.1 Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded “no”, skip to #2.) ☐ Yes ☐ No

A. If “yes” to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

☐ Yes ☐ No ☐ N/A

B. If “yes” to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

☐ Yes ☐ No ☐ N/A

C. If “yes” to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

☐ Yes ☐ No ☐ N/A

D. If “yes” to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If “yes”, please provide supporting documentation).

☐ Yes ☐ No ☐ N/A

8.2 Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

☐ Yes ☐ No

A. If “yes” to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

☐ Yes ☐ No ☐ N/A

8.3 Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If “No”, do not answer 8.3A.)

☐ Yes ☐ No

(continued on next page)

A. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

☐ Yes ☐ No ☐ N/A

8.4 Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 8.4A or 8.4B.)

☐ Yes ☐ No

A. Have you been in good standing with a state Medicaid program for the most recent five years?

☐ Yes ☐ No ☐ N/A

B. Did the termination occur at least 20 years before the date of this application?

☐ Yes ☐ No ☐ N/A

8.5 Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

☐ Yes ☐ No

8.6 If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)

☐ Yes ☐ No

9. DISCIPLINARY HISTORY Attach additional sheets, if necessary.

A. Have you ever had a professional healthcare license revoked, suspended, or otherwise acted against, including denial of licensure, by the licensing authority of this state or another state, territory or country? ☐ Yes ☐ No

B. Have you ever been notified to appear before any licensing authority on a complaint of any nature, including, but not limited to, a charge or violation for unprofessional or unethical conduct? ☐ Yes ☐ No

C. Have you ever been named or sued for malpractice? ☐ Yes ☐ No

D. Have you ever been disciplined, terminated or allowed to resign, in lieu of termination, from an employment setting where employed as a Registered/Certified Respiratory Therapist or in any capacity in the health care profession?

☐ Yes ☐ No

E. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of respiratory care? ☐ Yes ☐ No

If you answered "YES" to any of the above questions, please send a typed or printed description of the discipline. You must contact the board(s) in the states you were disciplined and request official copies of the administrative complaint and final order are sent directly to the board office. Please see application instructions for additional information regarding "yes" answers on this page.

NOTE: 456.013(3)(c): "In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied."

10. MANDATORY CONTINUING EDUCATION REQUIREMENT

Prevention of Medical Errors education requirement: Section 456.013(7), Florida Statutes, requires the completion of a 2-hour course relating to prevention of medical errors **prior to permanent licensure and upon each renewal in Florida as a registered/certified respiratory therapist.**

☐ I confirm I have completed the prevention of medical errors education required by Florida Statutes, as defined by Rule 64B32-6.006(4), F.A.C.

Provider Name: _____

Provider Number: _____

Course Title: _____

Date Completed: _____

☐ I have not completed the required course.

11. Section 456.38, Florida Statutes, Practitioner Registry for Disasters and Emergencies

Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐No

12. Applicants changing status from CRT to RRT: If you have a current Florida CRT license, once you are approved and issued a RRT license, do you wish to "Voluntarily relinquish your CRT license"?

☐ Yes ☐ No

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Name:			Social Security Number:
Last	First	Middle	

The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Answer questions in section 13 “YES" OR "NO" - Do not leave any blanks**. You may be required to make a personal appearance before the Board of Respiratory Care. A “YES" answer to section 13 must be accompanied by the following:**

3. **A written statement explaining in detail the circumstances surrounding the "YES" answer.** The statement must include all pertinent information such as date(s), explanation(s), address(es), employer(s), physician(s), institution(s), agency(ies) and hospital(s). Give a brief summary in the space given below and attach any statements to the application, numbering your response according to the number of the question for which you are attaching the statement.
4. Supporting documentation must also be submitted to verify the events, including court documents for **each offense**, providing arrest records, restitution or current circumstances, final disposition, etc. If the records are no longer available, you must have certification of their unavailability from the court.

13. PERSONAL HISTORY

A. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? ☐ Yes ☐ No

B. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? ☐ Yes ☐ No

C. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice respiratory care within the past five years? ☐ Yes ☐ No

D. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? ☐ Yes ☐ No

E. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice respiratory care within the last five years? ☐ Yes ☐ No

F. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice respiratory care? ☐ Yes ☐ No

If you answered “YES” to any of the above questions, please explain the circumstances surrounding your answer, on additional sheets. You must request an evaluation letter from treating physician(s); institution(s); etc. to support your application. Please see application instructions for additional information regarding “yes” answers on this page.

*** This page is exempt from public records disclosure.**

APPLICANT STATEMENT:

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentality's (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Chapter 456.013(1)(a) F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

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 on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida for the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further state that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

I hereby acknowledge that practice as a licensed Registered or Certified Respiratory Therapist in Florida is governed by Chapters 456 and 468, Part V, Florida Statutes, and Chapter 64B32, Florida Administrative Code. I understand that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 468, Part V, Florida Statutes and Chapter 64B32, Florida Administrative Code.

_____ _____

Signature of applicant (required) Date signed (required)

It is recommended that you do not make arrangements to accept employment as a Registered/Certified Respiratory Therapist in Florida until you have been issued a license by the Florida Board of Respiratory Care.

APPLICATION CHECKLIST

Use the following checklist to help ensure that you send in all necessary documentation for your licensure application.

____ Application - All questions answered? If question is not applicable, mark with N/A. Questions left blank will delay processing. **NOTE:** Mailing address will display on the Internet if you do not provide a practice location address.

____ Fees: $165 - ***Money order or check, certified or cashier preferred, payable to: Department of Health***

____ License verification(s) if licensed in another state(s) (if applicable)

____ NBRC Certification
- An official letter of verification directly from the NBRC. A copy of the NBRC test scores, wall credential or wallet card are ***NOT*** acceptable proof of this credential.

____ Statement(s) and/or Documentation for "YES" answers in Sections 7 – 9 and 13 (if applicable)

It takes approximately 7-10 working days for checks to be processed by the Department.
The Board office does not receive applications until fees have been processed.
Federal Express or special courier services will not expedite your process.

WHERE TO SEND APPLICATION AND SUPPORTING DOCUMENTS

INITIAL APPLICATION, FEES AND ANY SUPPORTING DOCUMENTS IN THE SAME ENVELOPE:
Florida Department of Health
Board of Respiratory Care
P.O. Box 6330
Tallahassee, FL 32314-6330

ALL DOCUMENTS NOT INCLUDED WITH APPLICATION AND FEE:
Florida Department of Health
Board of Respiratory Care
4052 Bald Cypress Way, BIN C-05
Tallahassee, FL 32399-3255

APPLICATION AND FEES SENT OVERNIGHT, SPECIAL DELIVERY:
Florida Department of Health
Licensure Services
4052 Bald Cypress Way, BIN C-99
Tallahassee, FL 32399-3299

Submission of supporting documents is encouraged prior to mailing your application.

****REMEMBER****

DO NOT START WORK IN FLORIDA UNTIL YOU HAVE RECEIVED A FLORIDA LICENSE

APPLICATION INSTRUCTIONS FOR LICENSURE BY ENDORSEMENT

It is your professional responsibility to read and understand this application package and the enclosed laws and rules governing the practice of respiratory care in Florida before completing your application. If another party is handling your application for you, it is still your responsibility to read, understand, and comply with all requirements for licensure.

Endorsement Licensure Requirements:

Certified Respiratory Therapist (CRT) OR Registered Respiratory Therapist (RRT)

- The applicant holds the "Certified Respiratory Therapist" or the "Registered Respiratory Therapist" credential issued by the National Board for Respiratory Care, or an equivalent credential acceptable to the Board; or
- The applicant holds certification, or the equivalent, to deliver respiratory care in another state and such certification was granted pursuant to requirements determined to be equivalent to, or more stringent than, the requirements in Florida.
- The applicant is not otherwise disqualified by reason of a violation of Chapter 456, or Chapter 468, Part V, Florida Statutes, or the rules promulgated there under.
- The applicant has completed a Board approved 2-hour course in medical error prevention meeting the criteria set forth in rule 64B32-6.006.

All Applicants Must Submit the Following:

Application: An applicant must complete and submit the application, fees and following documentation:

Fees for CRT or RRT: $165 ($50 non-refundable application fee, $110 licensure fee, $5 unlicensed activity fee) ***(Money order or check, certified or cashier preferred)***.

- This fee must accompany the application.
- The licensure fee ($115) may be refunded to you if you are denied licensure or if you decide to withdraw your application.

Verifications:

- ***Proof of having passed the NBRC exam*:** A certified respiratory therapist (CRT) or a registered respiratory therapist (RRT) who has passed the NBRC exam must contact the NBRC and have an official letter of verification forwarded to our office. ***Neither a copy of the NBRC passing scores, a copy of the credential nor a wallet card will be accepted, only the official letter of verification from the NBRC. Their web-site is www.NBRC.org or call them at (913) 599-4200.***

- ***Other state licenses you currently hold or have held, regardless of status***. You must notify the licensing state and pay any fees required by that state for this service.

Additional Education Requirement:

- **An applicant who has been out of the practice of respiratory care for 2 years or more** must complete a Board-approved comprehensive review course in order to ensure that he or she has sufficient skills to re-enter the profession. Board-approved comprehensive course means any course or courses which includes, at a minimum, fourteen contact education hours in the topics and numbers of hours as follows:

Patient assessment	3 hours
Hemodynamics	2 hours
Pulmonary Function	1 hour
Arterial blood gases	1 hour
Respiratory equipment	2 hours
Airway Care	1 hour
Mechanical ventilation	2 hours
Emergency care/special procedures	1 hour
General respiratory care (including medication)	1 hour

- **Prevention of Medical Errors:** Two (2) hours of prevention of medical errors education are required for initial licensure. The course can be completed by home study but must be given by a board-approved provider. You are not required to send a copy of your certificate to the board office.

HIV/AIDS Education Information

Once an applicant is licensed, the licensee will be required to complete a three hour approved course in HIV/AIDS prior to the first renewal of the license. Once the licensee has taken the course, he or she does not have to take it again.

Social Security Number

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.004(9), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and physical license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317). **You may apply for licensure before obtaining a social security number. However, you will not be issued a license until proof of a U.S. social security number is received.**

****** *Florida CRTs who become nationally registered and request RRT licensure will be required to complete a new application and fees.* In the State of Florida, the use of certain titles and abbreviations relative to the practice of respiratory care is allowed only by those individuals who fulfill the requirements of section 468.359, Florida Statutes. Individuals who use any of the protected titles or abbreviations affected by the above section and who are not eligible to do so are in violation of the practice act and may be subject to legal action.

No individual can use the title "Certified Respiratory Therapist" (CRT) or "Registered Respiratory Therapist" (RRT) in Florida if that individual is not licensed as such in Florida, regardless of whether that individual holds national certification. ***Individuals who are currently licensed as CRTs in Florida and who have obtained national certification may not sign as an RRT until their licenses have been changed to the registered level.*** The respiratory therapy application may be downloaded or requested through our web site at: www.flhealthsource.com .

Useful Tips for Completing the Application

- Within 30 days of receipt of your application, you will be sent:
  - A written or emailed deficiency notice regarding your application status OR you will receive your licensure letter. If your application is deficient, your deficiency letter will contain a direct link and login information to check the status of your application online. If you do not receive any correspondence from us within 30 days of the date your application was received by the Department, do not hesitate to contact the board office. **Please do not call to check on the status of your application until at least 30 days from the date you mailed your documentation.**

- The Board of Respiratory Care has a website, www.flhealthsource.com, which provides a "lookup licensee" screen where licensure status (once a permanent license has been issued) may be verified.

- All questions must be answered. If an item does not apply to you, mark "N/A". Any and all questions without an answer *will* delay the processing.

- Application fees are non-refundable. **Do not stop payment on your check.** This could result in a "bad check charge" being filed against you.

- It is your responsibility to ensure that the board office has received all documentation to complete your application.

- The application is valid for one year from the date we receive it. After a year, the application is expired and purged from our system. A new application and new documentation would need to be submitted.

- If questions arise regarding your eligibility for licensure during the review process, the application, once it is complete, will be referred to the board for review.

- **It is very important to keep the Board office informed of any change in mailing, practice location, email addresses and phone numbers. Please note: The US Postal Service does not forward Government mail**. Failure to notify the board office of any changes will delay the receipt of your license. **NOTE:** Mailing address will display on the Internet if you do not provide a practice location address.

- It is recommended that you keep these instructions and a copy of the completed application, should you need to refer to them during the processing of your application file.

- Social Security Numbers: If an applicant has met all licensure requirements, including passing the exams, the application will be held until a social security number issued. Social security numbers must be provided before a license is issued.

- Statement(s) to "YES" ANSWERS in response to the Criminal, Disciplinary or Personal History sections of the application must explain in detail the circumstances surrounding the answer. In addition to your statement(s) you must submit supporting documentation -- such as court documents providing arrest records, restitution records; evaluation letter(s) from treating physicians and/or institutions; employment records and/or employment verifications. Your answers may result in being referred to the Professionals Resource Network (PRN) for evaluation. PRN is a consultant to the State of Florida contracted to evaluate practitioners to ensure their ability to practice with reasonable skill and safety. Additionally, a "YES" answer to these questions may also require a personal appearance before the board.

  NOTES: 456.013(3)(c): In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.

  It is the licensee's responsibility to comply with the following statute: 456.072(1)(x), F.S., states: "Failing to report to the board, or the department if there is no board, in writing within 30 days after the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction.

  As a potential licensee, we recommend that you frequently visit the Board of Respiratory Care web site at: www.flhealthsource.com. We strive to continually update the website with information including, updates and changes in the profession, laws and rules, applications, instructions, a list of frequently asked questions (FAQ's), etc. that will assist you.

  HIV/AIDS Education Information: You will be required to complete a three hour approved course in HIV/AIDS prior to the first licensure renewal. Once you have taken this course, you will not have to take it again.

Please use the application checklist as a tool in completing your application

LICENSURE VERIFICATION FORM

PART I: TO BE COMPLETED BY APPLICANT

Complete this part and submit a copy to each jurisdiction where you hold or have ever held a license to practice respiratory care, making copies of this form as necessary.

Applicant Name: _____ SS#: _____

Address: _____

License Number: _____ Jurisdiction: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Respiratory Care.

Applicant Signature: _____ Date: _____

PART II: TO BE COMPLETED BY AN OFFICIAL OF THE LICENSURE ENTITY OF THE JURISDICTION

Please complete this part and return this form to the address listed below.

APPLICANT NAME: _____ JURISDICTION: _____

LICENSE NUMBER: _____ EXPIRATION DATE: _____ ISSUE DATE: _____

LICENSE BASED ON: STATE EXAM _____ NATIONAL EXAM _____
RECIPROCITY WITH _____ ENDORSEMENT _____

IS LICENSE IN GOOD STANDING? _____

HAS THE LICENSE EVER BEEN REVOKED OR SUSPENDED? _____

HAS ANY OTHER ACTION BEEN TAKEN AGAINST THIS APPLICANT? _____

REMARKS: _____

VERIFIED BY: _____
Signature of Official

BOARD SEAL

_____
Name

DATE: _____

_____
Title

DIVISION OF MEDICAL QUALITY ASSURANCE
Board of Respiratory Care
4052 Bald Cypress Way, Bin #C05 • Tallahassee, Florida 32399-3255
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http://www.flhealthsource.com