BOARD OF RESPIRATORY CARE

APPLICATION BY ENDORSEMENT

October 2018 Edition

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

4052 Bald Cypress Way, Bin # C05
Tallahassee, Florida 32399-3255
Phone: (850) 245-4373 Fax: (850) 414-6860
Website: www.FloridasRespiratoryCare.gov

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.

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) 895-4900.***

- ***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 not practiced respiratory care for 2 years** or more must complete a Board-approved comprehensive review course within two (2) years immediately prior to the filing of the licensure application or be recredentialed in the level in which he or she is applying to practice in order to ensure that he or she has the sufficient skills to re-enter the profession. Board-approved comprehensive course means any course or courses which includes, at a minimum, fourteen (14) 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

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.FloridasRespiratoryCare.gov

(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): _____

3. Email Notification: If you want to be notified of the status of your application by email please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office at: info@floridasrespiratorycare.gov

WORK NUMBER: _____

HOME NUMBER: _____

CELL NUMBER: _____

FAX NUMBER: _____

CORRESPONDENCE VIA E-MAIL? ☐ **YES** ☐ **NO**

E-MAIL ADDRESS:

_____

Please print legibly. By checking "yes", you agree to allow the board office to contact you with information regarding your application via e-mail. Under Florida law, e-mail addresses are public records. If you do not want your e-mail address released in response to a public records request, do not send electronic mail to this entity. Instead, contact this office by phone or in writing.

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 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.

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

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

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. 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

11. 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 12 “YES" OR "NO" - Do not leave any blanks**. You may be required to make a personal appearance before the Board of Respiratory Care**

12. PERSONAL HISTORY

A. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

B. Are you using medication, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

If you answered “yes” to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety and stating that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.

*** 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.

Under penalties of perjury, I declare that I have read the foregoing document, and the evidence presented herein for the purpose of demonstrating, to the satisfaction of the board, that I possess the qualifications preliminary to examination required by sections 486.041 and 486.103, or that I possess licensure in another state, the District of Columbia, or a territory as required by section 486.107, Florida Statutes, is true.

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.

____ 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 (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

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: http://floridasrespiratorycare.gov/resources .

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: ____________________

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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
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