



S.C. Department of Labor, Licensing and Regulation
Board of Medical Examiners



110 Centerview Drive, Suite 306
Post Office Box 12517
Columbia SC 29211
(803) 896-4501

**APPLICATION FOR A LICENSE TO PRACTICE
AS A RESPIRATORY CARE PRACTITIONER**

IMPORTANT: Read the enclosed requirements carefully before completing application. Appropriate fee of \$134 must accompany application; **application fee is non-refundable.** *The application form itself is a public document obtainable under the Freedom of Information Act.*

I hereby make application for a license to practice as a respiratory care practitioner in the State of South Carolina and submit the following statements of facts with the required supporting documents:

(Please type or print clearly)

Applicant's Name: _____
Last First Middle

Home Address: _____
City State Zip

Home Phone: () _____

Email Address: _____

S.C. Medical Director: _____
(If not known at this time, mark "unknown at this time")

Place of Employment in South Carolina: _____
(If not known at this time, mark "unknown at this time")

Street
City State Zip

Business Phone () _____

The SSN is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner DataBank (NPDB), among other things.

Rev. 7/08

I. PERSONAL DATA

Answer Yes or No

1. Has your Respiratory Care Practitioner certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? _____
2. Have you ever had an application to practice as a Respiratory Care Practitioner denied or refused by another licensing board or entity? _____
3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? _____
4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? _____
5. Are you currently under any investigation or the subject of pending disciplinary action by any licensing board or other entity? _____
6. Is your Respiratory Care Practitioner's certificate/license currently restricted in any way by any medical licensing board, health care facility or other entity? _____
7. Currently or within the last ten years, have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? _____
8. Has your ability to practice as a Respiratory Care Practitioner ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____
9. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? _____
10. Have you ever discontinued practicing as a Respiratory Care Practitioner for any reason for one month or more? _____
11. Have you ever been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state or local law (other than a minor traffic violation)? _____
12. Have you ever been known by any other name or surname? _____
13. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license? _____
14. Have you ever been discharged involuntarily from employment? If so, give full details. _____

NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.

II. EDUCATION

Attach copies of diplomas, degrees and certificates of training.

School attended Name and Address	Dates Attended From (Mo./Yr.) to (Mo./Yr.)	Diploma or Degree Received
High School:		
College:		
Respiratory Therapy Training:		
Graduate School:		

III. PROFESSIONAL INFORMATION

List all states in which you are licensed or certified to practice as a respiratory care practitioner (active/inactive).

State	License/Certificate Number	Date Issued	Basis of Licensure/Certification	Status (Active/Inactive)

III. PROFESSIONAL INFORMATION

(Continued)

1. Have you taken the entry level or higher level National Board for Respiratory Care, Inc. Examination?
_____ If so, please specify date and examination taken and whether you passed or failed.
_____ If registered, give your registry number _____.
A copy of your CRTT or RRT National Board certificate or examination results must be included with this application. Verification directly from NBRC may be required if appropriate documentation is not provided. Provide written explanation if certificate is not attached.
2. Have you ever taken any other state or national examination(s) in respiratory therapy? _____
If so, give the date(s), location and name of examination(s) taken, and indicate whether you passed or failed.
3. Do you plan to care for cardio-pulmonary patients in a home care setting? _____ If yes, you must attach a statement signed by your physician sponsor detailing the duties that you will perform and the type of supervision you will receive in performing these duties.

IV. EMPLOYMENT HISTORY

In chronological order (most recent first), list all employment relevant to training and/or work experience in respiratory therapy since graduating from your respiratory care program.

Place of Employment (Name of Company, City and State)	Dates of Employment	Title and Job Description

(Attach additional sheet of paper is needed)

IV. REFERENCES

(These persons should not be related to you by blood or marriage.) The references listed must be more than a casual acquaintance and of a substantial duration but need not be a respiratory care practitioner.

Please have statements from your references as to your moral character and fitness forwarded to the Board office on the enclosed Board form.

Name	Street or Mailing Address	Occupation
1.		
2.		
3.		

VI. AFFIDAVIT

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as a Respiratory Care Practitioner in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as a Respiratory Care Practitioner in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards and to federal and state entities, as required by law.

Applicant's Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public Signature: _____ (L.S.) For: _____

My Commission Expires: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10 SC Code of Law, **ALL** applicants for a South Carolina license after July 1, 2008 are required to complete and sign this Affidavit of Eligibility.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or
2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
 - a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
 - b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.
3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
 - a. ___ I am a US citizen, not physically present or employed in the United States.
 - b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided **upon request only**.

- Any South Carolina Driver License, South Carolina Driver Permit or South Carolina Identification Card, expired less than one year.
- Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year. State: _____
- Valid Temporary Resident Card
- Certificate of Naturalization with intact photo
- Certificate of (US) Citizenship with intact photo
- Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

(If issued by a state agency, include both the state and agency name.)

3. What is the secure and verifiable document number? _____

_____/_____/_____

Social Security Number

4. What is the expiration date of your secure and verifiable document? ____/____/____ (month/day/year)

(If you hold a document without an expiration date, such as a military ID or naturalization certificate, write N/A.)

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States. I may also be required to provide proof of lawful presence.
- I understand that in accordance with section 8-29-10 false statements made herein are punishable by law. I state under penalty of perjury that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Labor, Licensing and Regulation upon request and is subject to verification.

Signature

Date

=====

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Code of Laws requires that every individual who applies for an occupational or professional license provide a social security or alien identification number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

THIS SPACE FOR OFFICE USE ONLY

APPLICATION FOR
RESPIRATORY CARE PRACTITIONER
LICENSURE

Issued by the

South Carolina Department of Labor, Licensing
and Regulations
Board of Medical Examiners
110 Centerview Drive
Suite 306
Post Office Box 12517
Columbia, South Carolina 29211
(803) 896-4501

Approved by Board /Committee Member:

Board/Committee Member Signature

Date Approved

PHOTOGRAPH

NOTE: A recent portrait type photograph
must be pasted here. Photograph must be
passport size or snap shot.

GENERAL INFORMATION

Date of Birth: _____

Place of Birth: _____

Sex: _____ Race: _____

Height: _____ Weight: _____

SC Department of Labor, Licensing and Regulation
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(803) 896-4501
(803) 896-4525 Fax

REQUIREMENTS FOR A LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER

READ REQUIREMENTS CAREFULLY BEFORE COMPLETING APPLICATION.

I. GENERAL INFORMATION

The term Respiratory Care Practitioner encompasses both respiratory therapists and respiratory therapy technicians. Section 40-47-510 (5)

II. REQUIREMENTS FOR LICENSURE

In order to qualify for a license as a respiratory care practitioner the applicant must file a written application on forms provided by the Board and must show that he/she meets the following requirements (Section 40-47-600):

- (a) good moral character;
- (b) passage of the entry level examination given by the National Board for Respiratory Care, Inc., or other examination that may be approved.

III. FEES (Application fee is non-refundable)

The application fee for permanent licensure is \$134.

IV. APPLICATION FORM

The application form is self-explanatory. It sets forth the required supporting documents and/or information that must be submitted with your application. The Board **will not** consider an applicant for licensure until a complete application along with appropriate fee is submitted.

An application will be considered as incomplete until all of the following information is submitted:

- (a) all questions on the application answered fully;
- (b) all supporting documents and/or information required by application form received;
- (c) National Board examination results received;
- (d) State licenses/certificates verified;
- (e) application fee submitted.

V. PROCESSING TIME

Applications having all information with no identifiable problems will be expeditiously processed. Incomplete applications or problematic applications will require additional processing time.

When applying for licensure, if you do not know where you will be working in South Carolina and/or who the medical director is, please mark "unknown at this time in that space. Please remember, before you can begin working in South Carolina, you must notify the Board in writing of where you will be working, in South Carolina, and who the medical director will be.

POLICY OF THE BOARD REQUIRES INDIVIDUALS WHO HAVE NOT ACTIVELY PRACTICED RESPIRATORY CARE FOR FIVE (5) YEARS OR MORE TO TAKE AND PASS THE NBRC-ENTRY LEVEL EXAMINATION. PROOF OF PASSAGE MUST BE PROVIDED TO THE BOARD BEFORE YOUR LICENSE WILL BE ISSUED.

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REFERENCE FOR RESPIRATORY CARE PRACTITIONER APPLICANT

- Make copies of this form and provide to each reference
- Type or print clearly
- Individuals giving a reference should know you in a professional capacity. They cannot be related by blood or marriage

Applicant's Name: _____

Dates of Association: _____

Relation to Applicant: _____

Describe the applicant's moral character and fitness (attach a separate sheet of paper if necessary)

Moral Character: _____

Professional Competence: _____

Interpersonal Relations with Others: _____

Name (Print) _____

Address _____
Street City State Zip

Telephone Number (during business hours) _____

Signature _____ Date _____

Respiratory Care Verification of Licensure/Certification

Complete top portion and forward a copy to each State Medical Board where you have ever held approval to perform/practice as a Respiratory Care Practitioner. You may want to contact each state to see if a fee is required.

CLEARANCE FROM OTHER STATE BOARDS

In applying for a license to practice as a Respiratory Care Practitioner in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or ever held a license/certificate. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding myself directly to:

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Board of Medical Examiners
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Columbia, South Carolina 29211
(803) 896-4501
Fax (803) 896-4525

PLEASE TYPE OR PRINT

Signature _____
Name _____
Address _____

City State Zip

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the Board of Medical Examiners of South Carolina

Full Name of Licensee: _____
State of: _____ License/Certificate No.: _____
Date Issued: _____ Date Expires: _____
License/Certificate is current? _____ If no, why not? _____
Has license been suspended, revoked or restricted? _____ If yes, why? _____
Has licensee ever been required to appear before your Board? _____ If yes, why? _____
Derogatory information, comments if any _____

(Board Seal)

Signature: _____
Title: _____
State Board of: _____
Date: _____

ATTENTION CHECK WRITERS!!!

WE GLADLY ACCEPT YOUR CHECKS.
WHEN YOU PROVIDE A CHECK AS PAYMENT, YOU
AUTHORIZE US TO USE INFORMATION FROM THE CHECK
TO MAKE A ONE-TIME ELECTRONIC FUND TRANSFER
FROM YOUR ACCOUNT, OR TO PROCESS THE PAYMENT AS
A CHECK TRANSACTION.

YOU AUTHORIZE US TO COLLECT A FEE THROUGH
ELECTRONIC FUND TRANSFER FROM YOUR ACCOUNT IF
YOUR PAYMENT IS RETURNED UNPAID.