



**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 REACTIVATION OF  
RESPIRATORY CARE LICENSE**

**IMPORTANT:** I hereby make application for reactivation of my license to practice as a Respiratory Care Practitioner in the state of South Carolina and submit the following statement of facts with the required supporting documents: *The application form itself is a public document obtainable under the Freedom of Information Act.* The Application fee must accompany the application. **The application fee is non-refundable.**

(Please type or print clearly)

Applicant's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
City State Zip

Home Phone: ( ) \_\_\_\_\_

S.C. Respiratory Care License Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

S.C. Medical Director: \_\_\_\_\_

Place of Employment in South Carolina: \_\_\_\_\_

Street

City State Zip

Business Phones ( ) \_\_\_\_\_

\*Social Security Number: \_\_\_\_\_

**\*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 Data Bank (NPDB), among other things.**

CONTROL # \_\_\_\_\_

CHECK # \_\_\_\_\_

AMOUNT \$ \_\_\_\_\_

## I. PERSONAL DATA

Answer Yes or No

1. Has your Respiratory Care certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity?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 medical 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.**

**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 REACTIVATED.**

## II. PROFESSIONAL INFORMATION

1. 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 type of supervision you will receive in performing these duties.
  
2. Since your Respiratory Care Practitioner's license was placed on inactive status, list all employment activities in chronological order. Please include your place(s) of employment, date(s) of employment, job title and job duties:

Place(s) of Employment	Dates of Employment	Job Title & Job Duties

(Attach additional sheet if needed)

List all states in which you have ever been licensed or certified to practice as a Respiratory Care Practitioner. All State licenses/certificates must be verified directly from each state board. (form enclosed)

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

## III. REPORT OF CONTINUING EDUCATION

In order to reactivate your Respiratory Care License, you must provide documentation of at least thirty (30) hours of continuing medical education. Proof of attendance must be provided in the form of certificate, diploma or printout. These hours must be obtained within the last 2 years of this application.

Dates Attended	Sponsoring Agency	Name of Topic	Contact Hours

(Attach additional sheet if needed)

TOTAL CONTINUING MEDICAL EDUCATION HOURS \_\_\_\_\_

( 30 HOURS OF CME REQUIRED)

**III. REPORT OF CONTINUING EDUCATION**  
**(continued)**

**APPROVED CONTINUING EDUCATION PROGRAMS**

All programs sponsored or approved by one of the following organizations or their sponsors may be used to meet the continuing education requirement of the South Carolina Respiratory Care Practice Act.

- American Association for Respiratory Care, or its sponsoring organizations:
  - American Thoracic Society
  - American College of Chest Physicians
  - American Society of Anesthesiologists
- American Heart Association
- The Society for Critical Care Medicine
- The American Lung Association
- The South Carolina Society for Respiratory Care
- Allied Health Education Centers of the South Carolina Consortium of Community Teaching Hospitals

Accredited institutional continuing education programs will be accepted with certificate of attendance that specifies total number of contact hours. These continuing education programs must have been accredited by groups such as the Accreditation Council for Continuing Medical Education or the American Nurses Credentialing Center's Commission on Accreditation.

If the program is not approved by one of the above organizations, approval must be sought from the Respiratory Care Committee of the South Carolina Department of Labor, Licensing and Regulation. This approval must be sought 30 days prior to the program. Programs not having prior approval will be subject to review and may be denied. Approval must be applied for on forms provided by the Board. Content for these programs must be relevant to the professional growth and development of the Respiratory Care Practitioner.

Academic courses **may not** be used to meet the continuing education requirement of the South Carolina Respiratory Care Practice Act. **Medical directors no longer have signature approval authority.** If your continuing medical education credits are audited, you must show proof of attendance at the programs that are sponsored or approved by one of the above organizations. Proof of attendance must be provided in the form of a certificate, diploma or printout. Please direct any questions regarding the need for approval of continuing education programs to the Board office.

**IV. 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 respiratory care in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (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 physical 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 to the Board in connection with this application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations 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 in South Carolina.

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 \_\_\_\_\_

Sworn to me and subscribed before me this \_\_\_\_\_

day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_(L.S.) \_\_\_\_\_  
Signature of Notary Public for

My Commission Expires: \_\_\_\_\_

**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:

SC Dept. of Labor, Licensing and Regulation  
Board of Medical Examiners  
110 Centerview Drive, Suite 202  
Post Office Box 11289  
Columbia, South Carolina 29211-1289  
(803) 896-4500

**PLEASE TYPE OR PRINT**

Signature \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

**DO NOT DETACH**

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**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, if any Comments: \_\_\_\_\_

(Board Seal)

Signature: \_\_\_\_\_  
Title: \_\_\_\_\_  
State Board of: \_\_\_\_\_  
Date: \_\_\_\_\_

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

Insert 1

**REQUIREMENTS FOR REACTIVATION OF RESPIRATORY CARE LICENSE**

READ REQUIREMENTS CAREFULLY BEFORE COMPLETING APPLICATION.

**I. REQUIREMENTS FOR REACTIVATION**

In order to reactivate your South Carolina respiratory care practitioner license, the applicant must file a written application on forms provided by the Board and:

- (a) answer all questions on the application fully;
- (b) have all state licenses/certificates verified (active and inactive);
- (c) submit application fee of \$174;
- (d) provide 30 hours of CME obtained within the last 2 years of this application and;
- (e) provide a statement to the Board regarding your activity since your license was placed on inactive status by the Board. This statement must include all places of employment, job titles and job duties.

**II. FEES (Application fee is non-refundable)**

The biennial reactivation fee is \$174. (\$80 application fee, \$80 registration fee & \$14 RPP fee)

**III. APPLICATION FORM**

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

An application will be considered incomplete until all of the information listed in Section 1 is submitted:

**IV. PROCESSING TIME**

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

**V. NAME CHANGE**

If your name has changed since you last registered with this Board, you must provide a copy of the legal document (marriage license, divorce decree, etc.) before your name can be changed with this Board.

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