IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 • Boise, ID 83720-0058 • (208) 327-7000
Express Mail: 1755 Westgate Drive, #140 • Boise, ID 83704

APPLICATION – RESPIRATORY THERAPY LICENSURE

FOR USE OF THE BOARD					
1. Prof. Education	2. Recommendation	3. Recommendation	Received	Temporary	Permanent
4. Verification	5. NBRC	6. TP/Supervisor	Fees	Date	Date

Before completing, please see instructions.

I hereby apply for:

- ❑ Idaho Respiratory Therapy Licensure
- ❑ Temporary Permit

Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE

First Name	Middle Name	Last Name
Current Address (Street, City, State, Zip)		Telephone ( )
Change of Address (Street, City, State, Zip) Effective Date		Social Security No.
Place of Birth (City and State)		Date of Birth (Month, Day, Year)

Height (Ft., In.)	Weight	Hair	Eyes	Complexion	Scars, Marks	Sex: ❑ Male ❑ Female

NAME AND LOCATION OF SCHOOLS	FROM (Month, Day, Year)	TO (Month, Day, Year)
High School		
College/University		
Respiratory Therapy Program		
Postgraduate Study		

I HAVE APPLIED FOR LICENSURE IN THE FOLLOWING STATES OR COUNTRIES	YEAR	GRANTED CURRENT				NUMBER	APPLICATION BASED UPON		
		Yes	No	Yes	No		Endorse.	Recip.	Exam.

Rev. 5/00

In chronological order account for all periods of time beginning with the month applicant graduated from the respiratory therapy program up to the present time, leaving no gap in time of more than one month (employed, unemployed, studying for the exam, military service, extended vacation, etc.) Attach additional pages if necessary.

FROM (Month, Day, Year)	TO (Month, Day, Year)	NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION	EMPLOYER

NOTE

Attach a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 3"x4" in size. **Sign the photo in ink across the lower portion of the front side.**

Proof photos, negatives, copies, and instant photos are not acceptable.

CERTIFICATION

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

	YES	NO	
1.	❑	❑	Have you ever failed a licensing examination?
2.	❑	❑	Have you ever been refused a professional license?
3.	❑	❑	Have you ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations?
4.	❑	❑	Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct?
5.	❑	❑	Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration?
6.	❑	❑	Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety?
7.	❑	❑	Do you now or have you ever had hospital privileges removed or restricted, or limitations imposed on such privileges or resigned hospital privileges to avoid formal action?
8.	❑	❑	Do you currently have or have you had problems with the use of alcohol, stimulants, habit forming and / or illegal drugs in the past five years which in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety?

I, _____, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct; that I am the lawful holder of the degrees/credentials listed, and that such degrees/credentials were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board any information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice as a respiratory care practitioner.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation 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 with this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license as a respiratory care practitioner in the State of Idaho.

I further declare that the photo of myself attached hereto was taken on or about _____, 20_____, my age being _____.

State _____ County of _____, 20_____.

Subscribed and Sworn to before me this _____ day of _____, 20_____.

(SEAL) Notary Signature _____

My commission expires _____

_____
Signature of Applicant

CERTIFICATE OF PROFESSIONAL EDUCATION

Please have the following completed by the appropriate educational institution and returned directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, ID 83704.

Full Name of Applicant:	
Address:	
Social Security Number:	Date of Birth:
Associate Degree: Certificate of Completion:	Date of Degree: Date of Certification:

Dates of Attendance:	**From (Date)**	**To (Date)**
First Year		
Second Year		
Third Year		
Fourth Year		

I hereby certify that the above named respiratory therapist completed training as indicated above and received a certificate of completion. I further certify that at the time of such training and completion the program was approved by The American Medical Association.

(SEAL)

_____
Please type or print name of Dean/President/Secretary

_____
Signature of Dean/President or Secretary

_____
Name of School

_____
If changed, present name

_____
City State Zip

_____
Date of This Certification

Applicant's signature: _____

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice as a **respiratory care practitioner** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704. (Note: Two certificates of recommendation are required; please duplicate this form. Recommendations should be from persons who have known the applicant professionally for at least one year.

Applicant's Name: _____

Address: _____

_____

Recommending Person's Name: _____

Address: _____

Profession: _____

Do you request that this information be confidential? _____ Yes _____ No

TO: Idaho State Board of Medicine:

I have known_____for_____years,

from _____ to _____ while

he/she was studying or practicing as a respiratory therapist. To the best of my knowledge

he/she is of good moral and professional character and ethics.

Additional Comments:

_____

Signature

VERIFICATION OF REGISTRATION/LICENSURE

Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, ID 83704. (If additional forms are needed, this form may be duplicated.)

I am applying for licensure to practice as a **respiratory care practitioner** in the State of Idaho. The Idaho State Board of Medicine requires verification of registration/licensure from each state wherein I hold or have held registration/licensure. This is your authority to release any information in your files, favorable or otherwise, directly to the Idaho State Board of Medicine, at the address indicated above.

Applicant's Name: _____

Applicant's Address: _____

_____

My Registration/License No. is: _____

Do you request that this information be confidential? _____ Yes _____ No

State of: _____ Registration/License No.: _____ Issue Date: _____

Name of Registrant/Licentiate: _____

Issued by: _____ Endorsement/Reciprocity with: _____

_____ Examination (NBRC)

Status: Current Yes ____ No ____ Expiration Date _____

Do you have any record of disciplinary or legal action that should be considered with this respiratory therapist's application? Yes_____ No_____

Comments:

_____
Signature

_____
Title

(BOARD SEAL)

_____
Date

_____
State Board

Licensure Verification - Not an Endorsement