GENERAL CHECKLIST FOR RT TEMPORARY PERMIT APPLICANTS

*** Questions? E-mail claudia.lawson@bom.idaho.gov***

Fee must accompany application. **APPLICATION WILL NOT BE PROCESSED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE.** Amount due will be indicated on application. Checks or money orders are to be made payable to the Idaho State Board of Medicine. *Fees are nonrefundable.*

Applications must be on forms provided by the Board and all sections must be complete. Please type or print in ink. Applications must be legible.

Front page of application: If applicant has not applied for registration/licensure in other states, write "Not Applicable" in the appropriate section.

Back page of application:

Chronological account of time – Account for **all** periods of time beginning with the month of graduation to the present time, leaving **no gap** in time of **more than one month**. Attach additional pages if necessary.

Questions – Answer all questions 1-8. Provide details, for *YES* answers, on a separate sheet. Court documents will be required, if applicable.

Photo(s) – Does not need to be a professional photo. A **clear** and **in focus** 3"x4" snapshot taken of the head and shoulders only, with a digital camera, is a good choice. Passport photos are acceptable.

Notarized – Application must be notarized and signed in the appropriate place.

Certificate of Professional Education (Form 1): Fill in the top section. Be sure to indicate the degree **and** the field of study, the date degree was received, and sign **at the bottom** of the section. Send this form to the school (Registrar or Program Director) where applicant received professional education. The school will then send the form to the Board of Medicine.

Certificates of Recommendation (Form 2 & 3): Fill in the top section. Send this form to **two** individuals who have known the applicant professionally for at least **one** year (**no relatives**). Recommendations must be on the form provided or on letterhead addressed to the Board. Names and addresses must be legible.

Temporary Permit/Supervisor Affidavit (Form 6): This form may be duplicated. This is required from **every facility** where the applicant will be employed. Application must be notarized and signed. **NOTE:** Supervisor must have an active Idaho license.

FAXED and emailed supporting documents can be accepted, but the hard copy is preferred. The applicant's section of the application **cannot** be faxed. FAX# (208) 327-7005.

PLEASE NOTE: Forms received prior to receipt of application and licensure fee will be held in a "Misc. Forms" file for up to one year. After one year, the forms will be thrown away.

No practice is permitted prior to issuance of a permit number.

Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that a permit will be granted.

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	4. Verification	NBRC	Received
6. T/P Supervisor	NPDB-HIPDB	SSN Disclosure			Fee

I hereby apply for:

☐ **Respiratory Therapy Licensure** - Fee $100

☑ **Temporary Permit** - Fee $100

Please note: Fees are non-refundable

Make check payable to: IDAHO STATE BOARD OF MEDICINE

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

Height (*Ft., In.*)	**Weight**	**Hair**	**Eyes**	**Complexion**	**Sex:**
			...	...	...

NAME AND LOCATION *(CITY/STATE)* 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**
		Yes	**No**	**Yes**	**No**	

Rev. 08/14

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

FROM (Month, Year)	TO (Month, 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.

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

DO NOT STAPLE PHOTO TO APPLICATION

CERTIFICATION

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

	Y	N	
1.	☐	☐	Have you ever failed a licensure exam?
2.	☐	☐	Have you ever been refused a professional license/registration?
3.	☐	☐	Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome?
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 as a respiratory therapist with reasonable skill and safety?
7.	☐	☐	Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment 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 as a respiratory therapist 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/certificates 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 and 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 practicing as a respiratory therapist.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and 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 denial, suspension or revocation of my license to practice as a respiratory therapist in the State of Idaho.

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

State _____ County of _____

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 return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. #140, Boise, ID 83704; Fax: (208) 327-7005.

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

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

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

_____
Please type or print name of Director/ Registrar

_____
Signature of Director/Registrar

_____
Name of School or Facility

(SEAL)

_____
If changed, present name

_____
City State Zip Code

_____
Date of This Certification

_____
Applicant's signature

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice as a **respiratory therapist** 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; Fax: (208) 327-7005. (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: _____

_____

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 _____

Printed Name _____

Date _____

Address _____

_____

Profession _____

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice as a **respiratory therapist** 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; Fax: (208) 327-7005. (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: _____

_____

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 _____

Printed Name _____

Date _____

Address _____

_____

Profession _____

TEMPORARY PERMIT/SUPERVISOR AFFIDAVIT

I am applying for a temporary permit 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, ID 83720-0058; Express Mail: 1755 Westgate Dr., Ste. 140, Boise, ID 83704; Fax: (208) 327-7005.

Applicant's Name: _____

Address: _____

_____

FACILITY
Must provide a Supervisor Affidavit to the Board for each facility employed to practice respiratory care.

Name of Facility: _____

Address: _____
(Street) (Telephone)

_____
(City) (State) (Zip Code)

SUPERVISOR
Must be a permanent licensed respiratory care practitioner and/or physician and must complete the Supervisor Affidavit.

Name: _____
(Last) (First) (Initial)

Address: _____
(Street) (Telephone)

_____
(City) (State) (Zip Code) (Idaho License)

AFFIDAVIT OF SUPERVISOR
Applicant will work under my personal supervision and I assume responsibility for the applicant's work.

_____
Signature of Supervisor

State _____ County of _____

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

Notary signature _____

My commission expires _____

STATEMENT REGARDING DISCLOSURE OF SOCIAL SECURITY NUMBERS

The Idaho State Board of Medicine (hereinafter Board) requires disclosure of social security numbers on all applications for initial licensure and renewal. Disclosure of social security numbers is mandatory for purposes of enforcing child support orders under Idaho Code § 7-1416 and compliance with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank, as required by 45 CFR §§ 61.1 *et seq*. If this Board is required to make a report about an applicant or licensee to the Idaho Department of Health and Welfare or either of these data banks, the report must contain that individual's social security number. Failure to provide a social security number for these mandatory purposes will result in denial of an application for initial licensure or renewal.

An applicant for initial licensure or renewal may also voluntarily disclose his or her social security number for release to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation, such as the Federation of State Medical Boards' Physician Data Center. The Center compiles information about individual applicants and licensees and transmits that information to other licensing boards in order to coordinate licensure and disciplinary activities between the individual States. Such disclosure is for identification purposes only. Social security numbers will not be released for any other purpose not provided for or allowed by law.

I do ☐ do not ☐ give the Idaho State Board of Medicine permission to disclose my social security number to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation.

DATED This _____ day of _____, 20____.

_____ _____

Applicant's signature Applicant's printed name

Authorization for Release of Information

This form is to be completed by the applicant with the name(s) of any other individual(s) or entity(s), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc, and returned with the application. **Without this completed form, the Board may only discuss the pending status with the applicant.**

☐ I will be the only individual inquiring about the status of my application. If you are not authorizing the release of information to a third party, you will **not** need to have this form notarized, just sign and date below.

☐ I authorize the following individuals to inquire about the status of my application (see below):

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

_____
First Name Last Name Relationship to Applicant

_____
Name of Entity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

I hereby authorize and direct the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys at any time to release information regarding my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine to the individuals named above.

I further authorize the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys who have such information to consult with or discuss such information with any of the individuals named above.

Upon my knowledge and with legal consultation, I understand the nature of this Authorization for Release of Information with regard to my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine.

I, and my heirs, do hereby release the Idaho State Board of Medicine, Committee on Professional Discipline of the Idaho State Board of Medicine, and its members, employees, agents, officers, representatives, and attorneys, from all liability and all claims of any nature whatsoever pertinent to the information released.

Name of Applicant: _____
(First, Middle, Last)

Signature: _____ Date: _____

State of: _____
:ss
County of: _____

On this ____ day of _____, 20____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

I WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

_____
Notary Public for _____

Residing at: _____

My commission expires: _____

STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr., Ste 140
Boise, Idaho 83704
(208) 327-7000
FAX (208) 327-7005
E-Mail info@bom.idaho.gov
Website bom.idaho.gov

Credit Card Transmittal Form

~Print Legibly~

Order Information: _____

(Description of what & who payment is for)

Name as it appears on card: _____

Billing Address: _____

City _____ State _____ Postal Code _____

Telephone Number: _____

Card Number: _____-_____-_____-_____

Type of Card ☐ MasterCard ☐ Visa

Expiration (mm/yy) _____ Authorized Charge Amount: _____

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____

All fields (except email) are required in order to process payment/order.