

# MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

410-764-4777

[www.mpb.state.md.us](http://www.mpb.state.md.us)

Dear Applicant:

Attached is an application packet for reinstatement of your license as a Respiratory Care Practitioner in Maryland. The application fee is **\$200.00** and is **non-refundable**. Please make your check or money order payable to: **Maryland Board of Physicians**.

Mail your application and check to:

**Maryland Board of Physicians  
P.O. Box 37217  
Baltimore, MD 21297**

Please **DO NOT** mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. **Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.**

Applications are processed in order of receipt. **Please allow at least 3 to 6 weeks for the processing of your application.** Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

**Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact you if additional documentation is required. Please make sure your contact information is current.**

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school. Verification of national certification must come from the national certifying body and verification of other licenses must come from the state board that issued your license.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 6 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

The Board's website is updated every 24 hours. You may wish to check the website at [www.mbp.state.md.us](http://www.mbp.state.md.us) before calling the Board to find out if a license was issued to you. When you get to the website, click Search Practitioner Profiles.

We look forward to receiving your completed application and will process it as quickly as possible.

The Allied Health Division  
Board of Physicians

# MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217

Baltimore, Maryland 21297

Telephone: 410-764-4777 800-492-6836

[www.mpb.state.md.us](http://www.mpb.state.md.us)

## APPLICATION FOR REINSTATEMENT OF RESPIRATORY CARE PRACTITIONERS

### INSTRUCTIONS AND IMPORTANT INFORMATION

The application should only be completed by individuals who have a Maryland license as a Respiratory Care Practitioner, but the license expired.

- 1. Maryland License Number:** Enter your license number. If you not remember your license number, check the Board's website <https://www.mbp.state.md.us/bpqapp>.
- 2. Expiration Date:** Provide the date your license expired. Licenses expire on May 30 of even years. This may also be found on the Board's website.
- 3. Identifying Information:**
  - **Enter full legal name.** If the name on the application differs from the name on your supporting documentation, please submit a copy of a marriage license, divorce decree, or court order explaining the name change. The Board must be notified of any change in your name on a timely basis.
  - **Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:
    - A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
    - B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
    - C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
    - D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).
  - **Date of Birth:** Health Occupations Article §14-5C-09(b)(2), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.
  - **Gender:** Gender is not a requirement of licensure. The information provided will be used for identification purposes and for criminal background checks only.
- 4a. Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.
- 4b. Public Address:** The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public upon request.
- 5. Contact Information:** The Board will contact you using the information provided.

## ***INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED***

- 6. School Information:** Please provide name and location of the school from which you graduated.
- 7. Employment Activities:** Please complete and include all employment history beginning with the date your license expired.
- 8. Continuing Education:** Respiratory Care Practitioners applying for reinstatement must provide documentation of having earned at least 16 hours of continuing education during the two years immediately preceding the submission of the application for reinstatement. The Board will accept continuing education hours approved by the following organizations:
  - a. Maryland/District of Columbia Society for Respiratory Care;
  - b. AARC's Continuing Respiratory Care Education System; or
  - c. MedChi, the Maryland State Medical Society; or
  - d. Other programs:
    - (i) Having requirements equivalent to the programs accredited through the organizations listed in §C(1)(a) of this regulation; and
    - (ii) Approved by the Board.

An applicant for renewal or reinstatement may substitute passing the examination for either certified respiratory therapist or registered respiratory therapist conducted by the National Board for Respiratory Care during the 2-year period preceding the application for renewal or reinstatement for the required continuing education.

- 9. List reasons for allowing license to lapse.**
- 10. List reasons for seeking reinstatement of your Maryland license.**
- 11. Licensure in Other States:** Please complete the **Verification of Other State Licenses form (RCP 1)** if you have held a license, certification or registration to practice:
  - a. Respiratory Care in any state or jurisdiction; or
  - b. Any other health care profession in any other state(s) or jurisdiction, including Maryland.
- 12. Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation and the required supporting documentation will delay the review process.
- 13. Release:** Sign and date the release. You are giving the Board and the Respiratory Care Professional Standards Committee permission to request additional information to support your application for licensure.
- 14. Optional Third Party Release:** If you wish the Board to release your information to a third party, complete the third party release statement.
- 15. Cooperation in an Investigation:** You may be asked to cooperate fully with any request for information related to your practice as a Respiratory Care Practitioner.
- 16. Certification:** Please sign and date the certification.

***INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED***

**Expiration and Renewal:** Regardless of the date your license is reinstated, it will expire May 30th of the first even year following reinstatement. You will be notified when your license will expire approximately 30 - 60 days prior to expiration. The renewal notice will be mailed to the current address on file with the Board. **You will be required to renew by May 30 of the even year whether or not you receive the renewal notice.**

**PRACTICING RESPIRATORY CARE:** A person may not practice, attempt to practice, or offer to practice respiratory care in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides respiratory care unless the person is licensed to practice by the Board.

**The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board ADA designee, Ellen Douglas Smith at (410)764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Smith.**

**Please keep a copy of your application.**



# Maryland Board of Physicians

Check One:

Initial Licensure

Reinstatement

Name of Profession: \_\_\_\_\_

## ATTENTION

If You Are a Veteran, Service Member or Military Spouse

### PLEASE REVIEW AND COMPLETE BEFORE PROCEEDING

**“Veteran”** means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.

**“Veteran”** does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.

**“Military Spouse”** means the spouse of a service member or veteran,

**“Service Member”** means an individual who is an active duty member of:

**“Military Spouse”** includes a surviving spouse of:

- \* The Armed Forces of The United States
- \* A reserve component of the Armed Forces of the United States; or
- \* The National Guards of any state

- \* A veteran; or
- \* A service member who died within one year before the date on which the application for license, certification, or registration is submitted.

### Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

- Service Member – Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation..**
- Veteran – Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. **Provide supporting documentation.**
- Military Spouse: **Check the appropriate box**
  - Spouse is a Veteran. **Provide supporting documentation.**
  - Spouse was a service member who died within one year before the date of submitting the application. **Provide supporting documentation.**
  - Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. **Provide supporting documentation.**

\_\_\_\_\_  
Name of Applicant (PRINT)

\_\_\_\_\_  
Military Branch



**7. Chronology of Employment Activities: Beginning with your most recent, describe your employment history since your license expired. Explain any lapse in time over one year in which you were not employed. Include non-health related employment history.**

**Employment activities:** Please type or print.

month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		
month	year		month	year	Activity/Position:
		TO			
Name and telephone of Supervisor:			Name and Address of Employer:		

**CONTINUED ON PAGE 3:** If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

**Chronology** (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		
month	year		month	year	<b>Activity/Position:</b>
		TO			
<b>Name and telephone of Supervisor:</b>			<b>Name and Address of Employer:</b>		

**8. Continuing Education:** Respiratory Care Practitioners must earn at least **16 hours** of continuing education during the two years immediately preceding the submission of the application for reinstatement. The Board recognizes respiratory care continuing education hours approved by one of the following organizations: (a) MD/DC Society for Respiratory Care; (b) AARC's CRCE System; (c) MedChi, the Maryland State Medical Society; (d) Programs equivalent to a, b and c. Applicants may substitute passing the CRT or RRT exam during the 2-year period preceding the application.

**Please attach your 16 hours of continuing education documentation.**

**9. List reasons for allowing the Maryland respiratory care practitioner license to expire:**

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**10. List reasons for seeking reinstatement of the Maryland respiratory care practitioner license:**

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**11a. Licensure as a Respiratory Care Practitioner.** List all states or other jurisdictions in which ever held a license to practice respiratory therapy. Please complete and mail the attached **Verification of Other State License(s)** (RCP-R1) form to the appropriate state board(s). If you have never been licensed as a Respiratory Care Practitioner, write N/A here

\_\_\_\_\_.

State	License #	Category (CRT/RRT)	Year Issued	Expiration Date

**11b. Licensure as another health care practitioner.** List all states or other jurisdictions in which ever held a license to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s)** (RCP-R1) form to the appropriate state board(s). If you have never been licensed as a Respiratory Care Practitioner, write N/A here

\_\_\_\_\_.

State	License #	Category (RN, PA)	Year Issued	Expiration Date

## 12. Character and Fitness Questions (Check either YES or NO)

### Since your last renewal:

- |    | YES                      | NO                       |  |
|----|--------------------------|--------------------------|--|
| a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you been denied a license, certification or registration to practice any health occupation? <b>(e.g. state board orders and/or charges; adverse or disciplinary actions in any healthcare facility)</b>   |
| b. | <input type="checkbox"/> | <input type="checkbox"/> | Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? <b>(e.g. state board orders and/or charges; adverse or disciplinary actions)</b>  |
| c. | <input type="checkbox"/> | <input type="checkbox"/> | Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? <b>(e.g. state board orders and/or charges; adverse or disciplinary actions)</b>   |
| d. | <input type="checkbox"/> | <input type="checkbox"/> | Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? <b>(e.g. provide name of institution, correspondence received or sent, related documents.)</b>  |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? <b>(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)</b> |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? <b>(e.g. police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)</b>  |
| g. | <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have a physical or mental condition which may affect your ability to practice your profession? <b>(e.g. medical evaluations)</b>  |
| h. | <input type="checkbox"/> | <input type="checkbox"/> | Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? <b>(e.g. malpractice claims)</b>   |
| i. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, type of discharge. <b>(e.g. DD214)</b>   |
| j. | <input type="checkbox"/> | <input type="checkbox"/> | Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? <b>(e.g. copy of charges)</b>  |

»»» If you answered "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Examples of documentation are next to the question. Please note that these examples are not all inclusive. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

**13. Release:** I agree that the Maryland Board of Physicians (the Board) and Respiratory Care Professional Standards Committee may request any information necessary to process my reinstatement application as a Respiratory Care Practitioner in Maryland from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

\_\_\_\_\_  
Applicant's Name (Printed)

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**14. (OPTIONAL) Third Party Release:** Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**15. Cooperation in an Investigation:** I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed Respiratory Care Practitioner in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-5A-17.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**16. Certification:** I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 14-5A-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.11 which govern the practice of Respiratory Care Practitioners in Maryland.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

VERIFICATION OF OTHER STATE LICENSES

**Part 1** **APPLICANT:** Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license to practice Respiratory Therapy. Also send use this form to send to each state board, including Maryland, that ever issued you a certification, license or registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

License Type: \_\_\_\_\_

State of Licensure: \_\_\_\_\_ License Number: \_\_\_\_\_

Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 (Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No. : \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Professional School of Graduation: \_\_\_\_\_ Year: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2** **AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD:** Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

License number \_\_\_\_\_ Date Issued \_\_\_\_\_ Expiration Date \_\_\_\_\_

Is/was the license in good standing?  Yes  No

If not in good standing is/was it:  reprimanded  suspended  revoked  surrendered

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew?  Yes  No

If yes, please explain: \_\_\_\_\_

Other Derogatory Information or Pending Charges: \_\_\_\_\_

\_\_\_\_\_  
 Printed Name of Authorized Official

\_\_\_\_\_  
 Title of Authorized Official

\_\_\_\_\_  
 Signature of Authorized Official

\_\_\_\_\_  
 Direct Telephone Number

\_\_\_\_\_  
 Printed Name of State

\_\_\_\_\_  
 Date

