

MARYLAND BOARD OF PHYSICIANS

Baltimore, Maryland

410-764-4777

www.mpb.state.md.us

RESPIRATORY CARE PRACTITIONER APPLICATION FOR LICENSURE

Dear Applicant:

Attached is an application packet for licensure 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 7 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 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
Maryland Board of Physicians

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217

Baltimore, Maryland 21297

Telephone: 410-764-4775 or 800-492-6836

www.mpb.state.md.us

APPLICATION FOR LICENSURE OF RESPIRATORY CARE PRACTITIONERS

INSTRUCTIONS AND IMPORTANT INFORMATION

If you have been previously licensed in Maryland as a respiratory care practitioner, DO NOT USE THIS APPLICATION. Download a copy of the reinstatement application from the Board's website at www.mbp.state.md.us or call the number listed above and request a reinstatement application.

1. **Name:** If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.
2. **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.
3. **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.
4. **Contact Information (Telephones and E-mail Address):** The Board will contact you using the information provided.
5. **Date of Birth:** Health Occupations Article §15-303(a)(3), 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.
6. **Gender:** Disclosure of Gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.
7. **Race and Ethnicity:** Disclosure of race or ethnicity is not requirements of licensure, but the information provided will be used for identification purposes and for criminal background checks only.
8. **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).

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

- 9. Employment Activities:** Please complete and include all employment history beginning with the date you graduated from an accredited Respiratory Therapy educational program.
- 10. Verification of Professional Education:** Complete the top portion of the Verification of Professional Education form (RCP 1) and forward it to the CoARC or CAAHEP accredited respiratory therapy program from which you graduated.

If your school/program is no longer in existence, please either contact the Board of Higher Education or the Board of Education in the state where you attended the program. You may obtain the contact information by accessing www.statelocalgov.net/50states-education.cfm.

You may also wish to contact the Commission on Accreditation of Allied Health Education Programs (CAAHEP) at www.caahep.org or the Committee on Accreditation for Respiratory Care (CoARC) at www.coarc.org. These agencies accredit respiratory care programs and may have information on closed schools/programs.

- 11. National Certification:** Verification of certification from the National Board of Respiratory Care (NBRC). Applicants for licensure as a respiratory care practitioner must be currently certified by NBRC.

- 12. Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by:

a. Graduation from an English-speaking high school, undergraduate school, or professional school; **OR**

Provide evidence that you achieved a passing score on both the Test of Spoken English (TSE) **and** the Test of English as Foreign Language (TOEFL).

b. Achieve a passing score of at least 220 on the TSE **and** at least 550 TOEFL Paper and Pencil examination taken before July 1995; **OR**

c. Achieve a passing score of at least 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam Beginning July 1995; **OR**

d. Achieve a passing score of at least 26 on the spoken part **and** 79 on the written part of the TOEFL.

- 13. Licensure in Other States:** If you have ever held a license, certification or registration to practice as a respiratory therapist in any state or jurisdiction or in ANY other health care profession in any other states, including Maryland, complete the top portion of the Verification of Other State Licenses form (**RCP 2**) and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians in another profession, you do not need to complete the **RCP 2** form.

- 14. 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 of a "Yes" response and the required supporting documentation will delay the review process.

INSTRUCTIONS AND IMPORTANT INFORMATION CONTINUED

- 15. Release:** Sign and date the certification. You are giving the Board and Respiratory Care Professional Standards Committee permission to request additional information to support your application for licensure.
- 16. Optional Third Party Release:** If you wish the Board to release your information to a third party, complete the third party release statement.
- 17. 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.
- 18. Certification and Passport Quality Photo:** Sign and date the certification in the presence of a notary public after you have affixed a recent passport quality (2" x 2") photo to the application in the space provided.

Supplemental Forms RCP 1 and RCP 2 - Verification of Education (RCP 1): Complete this form and send it to the institutions where you completed your CoARC or CAAHEP accredited educational program.
Verification of Other State Licenses (RCP 2): Complete this form if you were issued a license/certification/registration as a respiratory therapist or ANY other health care provider.

Licensure and Renewal: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on May 30th of the first even year following the date on which you are initially licensed. You will have to renew your license if you plan to continue practicing in Maryland. The renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the most current address on file with the Board. **You will be required to renew your license on-line by May 30th of every 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:

- * 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.

- * 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

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

9. Chronology of Employment Activities: Beginning with the date you completed your Respiratory Therapy Program, list employment activities as a respiratory therapist. Also list any other health related employment. Explain any lapse over 1 year in which you were not employed. Please write N/A below if the statements do not apply to you. Please copy this page if you need more space. Sign and date all additional pages.

Graduation Date from CRT/RRT Program:
 Month: _____ Year: _____

Employment activities after graduation from Respiratory Therapy Program

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

10. EDUCATIONAL PROGRAM: Please complete this section and send the attached **Verification of Professional Education (RCP 1)** to your Respiratory Therapy program.

Name of School/Program

_____/_____/_____
Graduation Date

Degree and Type (Certificate, Associates, etc.)

Street Address

City

State

Zip Code

Telephone Number, including area code

11. National Certification: List the date and certification number.

NBRC Designation	Certification #	Certification Date	Expiration Date
<input type="checkbox"/> CRT	_____	_____/_____/_____	_____/_____/_____
<input type="checkbox"/> RRT	_____	_____/_____/_____	_____/_____/_____

12. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

- I graduated from a recognized English-speaking professional school; **OR**
- I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment; **OR**

I achieved a passing score of at least:

- 220 on the TSE and at least 550 TOEFL Paper **and** Pencil examination taken before July 1995; **OR**
- 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam beginning July 1995; **OR**.
- 26 on the spoken part **and** 79-80 on the written part of the TOEFL.

13 a. Licensure as a Respiratory Therapist. List all states or other jurisdictions in which ever held a license/certificate/ registration to practice as a Respiratory Therapist. Please complete and mail the attached **Verification of Other State Licenses** form (**RCP 2**) to the appropriate state board(s). If you have never been licensed as a Respiratory Therapist, write N/A here _____.

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

13 b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license/ certificate/registration to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s)** form (**RCP 2**) to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here _____.

State	License #	Category (EMT; Nurse, etc).	Year Issued	Expiration Date

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

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| a. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been denied a license, certification or registration to practice any health occupation? (ex: state board orders and/or charges; adverse or disciplinary actions in any healthcare facility) |
| 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? (ex: state board orders and/or charges; adverse or disciplinary actions) |
| 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? (ex: state board orders and/or charges; adverse or disciplinary actions) |
| 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? (ex: provide name of institution, correspondence received or sent, related documents.) |
| e. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever 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? (ex: 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) |
| f. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? (ex: 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) |
| 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? (ex: medical evaluations) |
| 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? (ex: malpractice claims) |
| 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. (ex: DD214) |
| 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? (ex: copy of charges) |

»»» 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 is 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.

RELEASE AND CERTIFICATION

15. Release: I agree that the Maryland Board of Physicians (the Board) and the Respiratory Care Professional Standards Committee may request any information necessary to process my application for initial licensure as a Respiratory Care Practitioner in Maryland from any person or agency, including but not limited to the NBRC, former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, 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

16. (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.

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

17. 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 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-14.

Applicant's Signature

Date

18. Certification: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

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

STATE OF _____

CITY/COUNTY OF _____

I HEREBY CERTIFY that on this _____ day of _____, 20____, before me, _____,

Name of Notary

a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, _____ whose

(Applicant's Name)

whose likeness is identifiable as that of the person in the photograph attached to this application and who who has made oath in due form of law that signing the foregoing application was his/her voluntary act and deed.

AS WITNESS my hand and notorial seal. _____

Notary Public

My Commission expires: _____

SEAL

APPLICANT:

PASTE YOUR PASSPORT-
QUALITY PHOTO HERE
BEFORE NOTARIZING

Respiratory Care Practitioners

Supplemental Forms

RCP 1—Verification of Professional
Education (Accredited CRT/RRT
Educational
Program)

RCP 2—Verification of Other State
Licenses

RCP 1
Verification of CRT/RRT
Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mpb.state.md.us

For Board Use Only
Program accredited?
Y _____ N _____
Date verified _____

**VERIFICATION OF PROFESSIONAL EDUCATION FOR
RESPIRATORY CARE PRACTITIONER LICENSURE**

Part 1 **APPLICANT:** Complete Part 1 and send to the institution where you completed your Respiratory Therapy program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: ____/____/____ Social Security Number: ____-____-____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: ____/____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2 **REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL:** Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

Associate's Degree Certificate Bachelor's Degree Master's Degree Other: _____
(specify)

in _____ Educational Program. The program was accredited by: _____
CoARC, CAAHEP, CAHEA, etc.

Printed Name of Authorized Official _____ Name of Institution _____

Title of Authorized Official _____ Telephone Number _____ Fax Number _____

Signature of Authorized Official _____ Date _____

**SEAL
OF THE
INSTITUTION**

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/certificate/registration to practice as a Respiratory Therapist. Also send use this form to send to each state board, including Maryland, that ever issued you a license/certification/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

