



APPLICATION FOR A LICENSE AS A RESPIRATORY CARE PRACTITIONER

State Form 43825 (R7 / 8-16)

Approved by State Board of Accounts, 2016

**RESPIRATORY CARE COMMITTEE
PROFESSIONAL LICENSING AGENCY**
 402 West Washington Street, Room W072
 Indianapolis, Indiana 46204
 Telephone: (317) 234-2054
 E-mail: pla8@pla.IN.gov
 www.pla.IN.gov

- INSTRUCTIONS:**
1. The fee for this application is \$50.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 11-2-1.1.
 2. If applying for a temporary permit, please include your fee of \$25.00 in accordance with 844 IAC 11-2-1.1.
 3. All fees are non-refundable and non-transferable.
 4. Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

Application Fee	Temporary fee	APPLICANT <i>Attach one (1) passport type quality photographs of yourself taken within the last eight (8) weeks.</i>
Date fee paid (month, day, year)	Date fee paid (month, day, year)	
Receipt number	Receipt number	
License number issued	Temporary permit number issued	
License issuance date (month, day, year)	Temporary permit issuance date (month, day, year)	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)		Social Security number *
Address (number and street or rural route, city, state, and ZIP code)		
Date of birth (month, day, year)	Place of birth (city and state or country)	
Telephone number (daytime) ()	E-mail address	
Are you the spouse of a member of the military who is assigned to a duty station in Indiana? (Optional)	Are you an active duty member of the military? (Optional)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**BASIS FOR LICENSURE
(Please check one)**

<input type="checkbox"/> EXAMINATION	Based upon applying to take the NBRC Examination.
<input type="checkbox"/> ENDORSEMENT	Based upon being licensed in another state or coming from a state that does not license or certify but is credentialed by the NBRC.
<input type="checkbox"/> CREDENTIALS	Based upon your NBRC Certification only. (You may not apply based upon credentials if you are licensed or certified in another state or are coming from a state that does not license or certify respiratory care practitioners.)

TEMPORARY PERMIT INFORMATION

Do you wish to have a temporary permit issued pending your application for licensure? Yes No

GRADUATE OF A SCHOOL OR PROGRAM OF RESPIRATORY CARE

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION (month, day, year)

EXAMINATION RECORD

EXAMINATION TAKEN	DATE OF MOST RECENT EXAMINATION (month, day, year)	WHERE TAKEN	HOW MANY TIMES HAVE YOU SAT FOR THIS EXAMINATION
National Board for Respiratory Care (NBRC)			
Other _____			

Have you ever failed the NBRC examination? Yes No

UNDERGRADUATE AND GRADUATE TRAINING

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED	DEGREE GRANTED

STATES LICENSED

Do you hold or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? Yes No
 If yes, please list all states, including Indiana, in which you have been licensed to practice as a Respiratory Care Practitioner, or any other health related occupation.

LICENSE TYPE	STATE	NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION

GENERAL LOCATION	DATES

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION

NAME OF EMPLOYER AND ADDRESS	RESPONSIBILITIES	DATES OF EMPLOYMENT

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

- Have you ever previously filed an application in the State of Indiana? Yes No
- Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held? Yes No
- Have you ever been denied a license, certificate, registration or permit to practice respiratory care or any regulated health occupation in any state (*including Indiana*) or country? Yes No
- Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*

(1) have you ever been arrested; Yes No

(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; Yes No

(3) have you ever been convicted of any offense, misdemeanor, or felony in any state; Yes No

(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or Yes No

(5) have you ever pled *nolo contendere* to any offense, misdemeanor, or felony in any state? Yes No
- Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? Yes No
- Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? Yes No
- Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? Yes No
- Have you ever had a malpractice judgment against you or settled any malpractice action?

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (<i>month, day, year</i>)
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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professions Licensing Agency and the Respiratory Care Committee any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for a license to practice respiratory care.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

A photostatic copy of this authorization has the same force an effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to the same.

Signature of applicant

Date signed (*month, day, year*)

**VERIFICATION OF LICENSURE
RESPIRATORY CARE PRACTITIONER**

INSTRUCTIONS: Please complete the top portion of the verification and send a copy to each state where you hold or have held a license. Request each state to complete and send directly to:

**RESPIRATORY CARE COMMITTEE
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov

APPLICANT INFORMATION

Name (last, first, middle, maiden)		Social Security number *	
Address (number and street or rural route)			
City		State	ZIP code
Date of birth (month, day, year)	Telephone number (daytime) ()	E-mail address	
I hereby authorize the State of _____, to furnish the Professional Licensing Agency with the information below.			
Signature		Date signed (month, day, year)	

TO BE COMPLETED BY THE STATE BOARD

License number	Date of issuance (month, day, year)	Expiration date (month, day, year)
License issued based upon:		
<input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> National Board of Respiratory Care (NBRC) Credential <input type="checkbox"/> Other: _____		
Type of examination:	Date of examination(s) (month, day, year)	
<input type="checkbox"/> NBRC <input type="checkbox"/> State Constructed Examination (Attach subjects, scores and average)		
Has this license been subject to any disciplinary action? (Please attach certified copies of any disciplinary action taken by your board.)		
		<input type="checkbox"/> Yes <input type="checkbox"/> No

FORM COMPLETED BY:

Name	PLEASE AFFIX BOARD SEAL
Title	
State Board	
Date (month, day, year)	