Reset Form

APPLICATION FOR A LICENSE AS A RESPIRATORY CARE PRACTITIONER

State Form 43825 (R11 / 3-25)

RESPIRATORY CARE COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-8800
E-mail: pla14@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. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *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.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Application Fee	
Date fee paid *(month, day, year)*	
Receipt number	
License number issued	
License issuance date *(month, day, year)*	

Temporary fee	
Date fee paid (*month, day, year*)	
Receipt number	
Temporary permit number issued	
Temporary permit issuance date *(month, day, year)*	

APPLICANT

Attach one (1) passport type quality photographs of yourself taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

BASIS FOR LICENSURE (*Please check one.*)

☐ **EXAMINATION**	Based upon applying to take the NBRC Examination.
☐ **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.
☐ **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

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, 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. Do not file this application without this documentation.

1. Have you ever previously filed an application in the State of Indiana? ☐ Yes ☐ No

2. Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held? ☐ Yes ☐ No

3. 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

4. *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 contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

5. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner? ☐ Yes ☐ No

6. 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

7. 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

8. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency 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 licensure.

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 information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

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

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)
	99

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) 234-8800
E-mail: pla14@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 98, to furnish the Professional Licensing Agency with the information below.

Signature	Date signed (*month, day, year*) 979

TO BE COMPLETED BY THE STATE BOARD

License number	Date of issuance (*month, day, year*)	Expiration date (*month, day, year*)

License issued based upon:

☐ Examination ☐ Endorsement ☐ National Board of Respiratory Care (NBRC) Credential
☐ Other: _____

Type of examination:	Date of examination(s) (*month, day, year*)
☐ NBRC ☐ 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.*) ☐ Yes ☐ No

FORM COMPLETED BY:

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