Reset Form

APPLICATION FOR STUDENT PERMIT TO PRACTICE RESPIRATORY CARE

State Form 50819 (R5 / 9-17)
Approved by State Board of Accounts, 2017

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 $25.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 11-2-1.1.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
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.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

APPLICATION FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
STUDENT PERMIT NUMBER	
STUDENT PERMIT ISSUE DATE (*month, day, year*)	
STUDENT PERMIT EXPIRATION DATE (*month, day, year*)	

APPLICANT
Attach one (1) passport type quality photograph 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 one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

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

BASIS OF APPLICATION (*please check one*)

☐	New applicant - applying for the first time for a student permit
☐	Change of hospital or facility of employment
☐	Additional hospital or facility employment - adding an additional hospital or facility of employment
☐	Change of respiratory care procedures - adding additional procedures the student permit holder may provide
☐	Transfer of school
☐	Change of graduation date

Do you hold or have you ever held a student permit? ☐ Yes ☐ No

If yes, please list student permit number(s).

SCHOOL OR PROGRAM OF RESPIRATORY CARE CURRENTLY ENROLLED

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

OTHER SCHOOLS OR PROGRAMS ATTENDED

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED (*month, day, year*)	DEGREE GRANTED (*month, day, year*)

OTHER SCHOOLS OR PROGRAMS ATTENDED *(continued)*

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 explain.

LIST ALL PLACES YOU HAVE LIVED SINCE ENROLLING IN YOUR SCHOOL OR PROGRAM

GENERAL LOCATION	DATES *(month, day, year)*

LIST ALL PLACES WHERE YOU HAVE BEEN EMPLOYED TO PRACTICE RESPIRATORY CARE PRIOR TO APPLYING FOR A STUDENT PERMIT

EMPLOYER	ADDRESS *(number and street, city, state, and ZIP code)*	DATES OF EMPLOYMENT *(month, day, year)*

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.

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. 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
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

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 (*month, day, year*)

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 their authorized representatives in connection with processing my application for a student permit to practice repertory 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 and effect as the original.

AFFIRMATION

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

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

I understand the following as a holder of a student permit:

I shall meet in person at least one (1) time each working day with my supervising practitioner or a designated respiratory care practitioner to review the permit holder's clinical activities. The supervising practitioner or a designated respiratory care practitioner shall review and countersign the entries that the permit holder makes in the patient's medical record not more than seven (7) calendar days after the permit holder makes the entries.

I may only perform procedures that I have successfully completed and documented in the respiratory care program, AND that the Committee has approved and are on file at the Professional Licensing Agency.

The procedures permitted may be performed ONLY on adult patients who are not critical care patients and under the proximate supervision of a licensed respiratory care practitioner. This means that the student permit holder may not perform blood gas sampling and analysis, work in ICU, ER, or Pediatrics.

The student permit holder, working under the student permit, MAY NOT perform blood gas sampling and analysis, work in ICU, ER, and Pediatrics after graduation. The new graduate may work in the above-mentioned areas ONLY after applying for AND receiving a temporary permit, as described above.

A student permit expires on the earliest of the following:

- The date a student permit holder is issued a respiratory care license or temporary permit.
- The date the Committee disapproves the student permit holder's application for a license.
- The date the student permit holder ceases to be a student in good standing in a respiratory care program.
- Sixty (60) days after the date that the student permit holder graduates from a respiratory care program.
- The date that the student permit holder is notified that he / she failed the licensure examination.
- Two (2) years after the date of issuance.

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

PART II.
APPLICATION FOR A STUDENT PERMIT TO PRACTICE RESPIRATORY CARE
HOSPITAL OR FACILITY OF EMPLOYMENT

Part of State Form 50819 (R5 / 9-17)

(*This form is to be completed by the hospital or facility where the applicant will be employed*.)

NAME OF STUDENT	
Name of student	Social Security number *

NAME OF LICENSED RESPIRATORY CARE PRACTITIONER SUPERVISOR DESIGNEE	
Name of RCP supervisor designee	
Respiratory care license number	Expiration date (*month, day, year*)
Telephone number ( )	E-mail address

HOSPITAL OR FACILITY OF EMPLOYMENT		
Name of hospital or facility		
Address (*number and street or rural route*)		
City	State	ZIP code

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 licensed respiratory care practitioner	Date signed (*month, day, year*)

SUPERVISION OF STUDENT PERMIT HOLDER

ACCORDING TO IC 25-34.5-2-14(f) & (g):

(f) A holder of a student permit shall meet in person at least one (1) time each working day with the permit holder's supervising practitioner or a designated respiratory care practitioner to review the permit holder's clinical activities. The supervising practitioner or a designated respiratory care practitioner shall review and countersign the entries that the permit holder makes in a patient's medical record not more than seven (7) calendar days after the permit holder makes the entries.

(g) A supervising practitioner may not supervise at one (1) time more than three (3) holders of student permits issued under this section.

IF THE STUDENT PERMIT HOLDER LEAVES YOUR EMPLOYMENT YOU MUST NOTIFY THE RESPIRATORY CARE COMMITTEE.

Please return this application to the following address:

Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

Telephone: (317) 234-2054
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PART III.
APPLICATION FOR A STUDENT PERMIT TO PRACTICE RESPIRATORY
SCHOOL OR PROGRAM OF RESPIRATORY CARE
PROCEDURES COMPLETED BY THE STUDENT PERMIT HOLDER

Part of State Form 50819 (R5 / 9-17)

(*To be completed by the Program Director and Director of Clinical Education of the Respiratory Care School or Program.*)

APPLICANT INFORMATION	
Name of student	Social Security number *

SCHOOL OR PROGRAM OF RESPIRATORY CARE		
Name of school or program		
Date of admission (*month, day, year*)	Date of expected graduation (*month, day, year*)	
Address (*number and street or rural route*)		
City	State	ZIP code
Name of program director		
Telephone number ( )	E-mail address	
Name of program director of clinical education		
Telephone number ( )	E-mail address	

AFFIRMATION	
I hereby swear or affirm that the applicant is a student in good standing in a program or school of respiratory care which is approved by the Indiana Respiratory Care Committee and the applicant has successfully completed the list of procedures which is attached to this application.	
Signature of program director	Date signed (*month, day, year*)
Signature of program director of clinical education	Date signed (*month, day, year*)

The program director or director of clinical education must notify the Indiana Respiratory Care Committee if the student ceases to be in good standing in the respiratory care program. Failure to do so may be grounds for disciplinary action.

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RESPIRATORY CARE PROCEDURES

Please check-off the procedures which have been a part of a course that the applicant has successfully completed in the respiratory care program and completion has been documented in both lecture and lab, and also in clinical.

Please note that the procedures permitted may be performed only:
(1) on adult patients who are not critical care patients; and
(2) under the proximate supervision of a licensed respiratory care practitioner.

PROCEDURES	
1. Aerosol Medication Delivery	☐ Completed
2. Airway Clearance Techniques	☐ Completed
3. Capnography	☐ Completed
4. Chest Physiotherapy	☐ Completed
5. Completion of Basic Respiratory Pharmacology	☐ Completed
6. Cylinders	☐ Completed
7. Directed Cough Technique	☐ Completed
8. EKG	☐ Completed
9. Endotracheal Suctioning	☐ Completed
10. Flow Meters	☐ Completed
11. Gas Regulators	☐ Completed
12. Humidity and Aerosol Therapy	☐ Completed
13. Incentive Spirometry	☐ Completed
14. Intermittent Volume Expansion	☐ Completed
15. Liquid Systems	☐ Completed
16. Manual Ventilation	☐ Completed
17. Medical Records	☐ Completed
18. Metered Dose Inhaler	☐ Completed
19. Minute Ventilation	☐ Completed
20. Nasotracheal Suctioning	☐ Completed
21. Oxygen Analysis	☐ Completed
22. Oxygen Therapy	☐ Completed
23. Oxygen / Medical Gas Administration	☐ Completed
24. Patient Interview and History	☐ Completed
25. Peak Flow	☐ Completed
26. Pharyngeal Airway Insertion	☐ Completed
27. Physical Assessment of Chest	☐ Completed
28. Spirometry Screening	☐ Completed
29. Sputum Inductions	☐ Completed
30. Tidal Volume	☐ Completed
31. Tracheostomy Care	☐ Completed
32. Transutaneous Monitors	☐ Completed
33. Standard Precautions	☐ Completed
34. Vital Capacity	☐ Completed
35. Vital Signs	☐ Completed