Reset Form

APPLICATION FOR STUDENT PERMIT TO PRACTICE RESPIRATORY CARE

State Form 50819 (R10 / 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 $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.

FOR OFFICE USE ONLY		
Application fee	Date fee paid (*month, day, year*)	Receipt number
Student permit number	Date of issue (*month, day, year*)	Date of expiration (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

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

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)*	Are you an active duty member of the military? *(Optional)*
Yes ☐ No	☐ Yes ☐ No

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)*

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS.

Verification of all licenses listed must be submitted directly from the state licensing board.

STATE	TYPE OF LICENSE / CERTIFICATE	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

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

2. 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

3. *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

4. 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

5. 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

6. 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

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*)

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

Part of State Form 50819 (R9 / 8-24)

(*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

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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 (R9 / 8-24)

(*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 patients who are not critical care patients; and
(2) under the proximate supervision of a practitioner.

PROCEDURES	
1. Aerosol Medication Delivery with completion of basic respiratory pharmacology course (for example; nebulizers, MDIs, DPIs, SMIs, and sputum inductions)	☐ Completed
2. Basic Lung Parameters (for example; minute ventilation, tidal volume, vital capacity, and peak flow)	☐ Completed
3. Bronchopulmonary hygiene - basic (for example; airway clearance, CPT, or directed cough)	☐ Completed
4. Bronchopulmonary hygiene - advanced (for example; "Vest" or cough assist)	☐ Completed
5. Capnography	☐ Completed
6. EKG	☐ Completed
7. High Pressure gas equipment (for example; cylinders, gas regulators, and flow meters)	☐ Completed
8. Humidity and Aerosol Therapy (for example; large volume nebulizers and high flow nasal cannula)	☐ Completed
9. Oxygen Therapy (including oxygen analysis, devices and liquid systems)	☐ Completed
10. Medical chart review	☐ Completed
11. Patient Assessment - basic (for example; vital signs, SpO_2, and breath sounds)	☐ Completed
12. Patient Assessment - advanced (for example; physical assessment of the chest, inspection, palpation, percussion, chest radiograph review, patient interview and history)	☐ Completed
13. Pharyngeal Airway Insertion	☐ Completed
14. Pulmonary Volume Expansion - basic (for example; IS, PEP, or PAP)	☐ Completed
15. Pulmonary Volume Expansion - advanced (for example; IPV or Metaneb)	☐ Completed
16. Suctioning (for example; trach, nasotracheal or endotracheal)	☐ Completed
17. Tracheostomy Care	☐ Completed