

APPLICATION FOR STUDENT PERMIT TO PRACTICE RESPIRATORY CARE

State Form 50819 (R2 / 6-13) Approved by State Board of Accounts, 2013

INSTRUCTIONS: Please type or print all information.

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

* Your Social Security number is requested by this a	agency in accorda	ince with IC 4-1-8-1, and it	is mandatory th	at it be give	en.		
APPLICATION FEE							
DATE FEE PAID (month, day, year)						LICANT	
RECEIPT NUMBER				I	Attach one ype quality		-
				1 -	yourself ta		-
STUDENT PERMIT NUMBER					last eig	ght weeks	i.
STUDENT PERMIT ISSUE DATE (month, da	ay, year)						
STUDENT PERMIT EXPIRATION DATE (mo	onth, day, year)						
	DO NOT V	VRITE ABOVE THIS LII	NE				
	APPL	ICANT INFORMATION					
Name of applicant (last, first, middle, maiden)				Social Se	ecurity numbe	∍r *	
Address (number and street or rural route)							
		I.e.					
City		State			ZIP code		
Date of birth (month, day, year)		Place of birth (city and state or country)					
Telephone number (daytime)		Email address					
()		Linali address					
	BASIS OF AP	PLICATION (please check	cone)				
New applicant - applying for t	he first time for a	student permit					
Change of hospital or facility of	of employment						
Additional hospital or facility e	employment - addi	ng an additional hospital or	facility of empl	oyment			
Change of respiratory care pr	rocedures - 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 per If yes, please list student permit number(s).	mit?					Yes	☐ No
n yes, preuse not student permit number(s).							
SCHOOL OR	PROCEAN OF F	RESPIRATORY CARE CUF	DENTI V END	OLLED			
NAME OF SCHOOL		OF SCHOOL	DATE ENTER		E OF EXP	ECTED GF	RADUATION
		<u> </u>		122 271			
	OTHER SCHOOL	DLS OR PROGRAMS ATTI	ENDED				
NAME OF SCHOOL		LOCATION OF SCHOOL	INDED	DATES AT	TENDED	DEGREE	GRANTED
10.1112 01 0011002							
Do you hold or have you ever held, a license, cer		tion or permit to practice	any regulated	health occ	upation?	 ☐ Yes	☐ No
If yes, please explain in the space located below	<i>'</i> .						

LIST ALL BLACES VO	DU HAVE LIVED SINCE ENROLLING IN YOUR SCHOOL OF	PROCEAM		
	NERAL LOCATION	RPROGRAM	DATES	
LIST ALL DI ACES WHERE VOLLHAVE REEN EI	MPLOYED TO PRACTICE RESPIRATORY CARE PRIOR TO	A A B BI VING FOR A	STUDENT E	EDMIT
EMPLOYER	ADDRESS		OF EMPLO	
	in fully in a signed and notarized statement, including all relacepted in lieu of your statement. Falsification of any of the follo			
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 (<i>including Indiana</i>) 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; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled nolo contendre to any offense, misdemeanor, or felony in any state? 				□ 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?				□ 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
	primanded or requested to withdraw, resign or retire from any f membership or privileges or acted as a consultant?	hospital or health	☐ Yes	□ No
I be a short a constant of the second state of	APPLICATION AFFIRMATION	nlata and assurant		
Signature of applicant	ury, that the statements made in this application are true, com	Date signed (month, da	y, year)	
	UTHORIZATION FOR RELEASE OF INFORMATION			
Agency any files, documents, records or other information	irm, officer, corporation, association, organization or institution mation pertaining to the undersigned requested by the Agency oplication for a student permit to practice repertory care.			ensing
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 sam	e force and effect as the original.			
	AFFIRMATION			
I hereby swear or affirm, that I have read the above	statements and agree to same.	Data signed (month da	v voar)	
Signature of applicant		Date signed (month, day	y, 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

(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 CARI	E PRACTITIONER SUPERVISOR D	ESIGNEE		
Name of RCP supervisor designee				
Respiratory care license number	Expiration date (month, day, year)			
Telephone number	Email address			
()				
HOSPITAL OR FACIL	ITY 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 E-mail: pla8@pla.IN.gov

PART III. APPLICATION FOR A STUDENT PERMIT TO PRACTICE RESPIRATORY SCHOOL OR PROGRAM OF RESPIRATORY CARE PROCEDURES COMPLETED BY THE STUDENT PERMIT HOLDER

(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 *
90	CHOOL OR PROGRAM OF RESPIRATORY CA	ARE
Name of school or program	SHOOL ON PROGRAM OF RESPIRATORY C.	AND
Date of admission (month, day, year)	Date of expected gradua	tion (month, day, year)
Address (number and street or rural route)		
City	State	ZIP code
Name of program director		I
Telephone number	Email address	
Name of program director of clinical education	'	
Telephone number ()	Email address	
	AFFIRMATION	
I hereby swear or affirm that the applicant is a student Respiratory Care Committee and the applicant has su		
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 edu-	ication must notify the Indiana Respiratory	Care Committee if the student ceases to be in

Please return this application to the following address:

Professional Licensing Agency

good standing in the respiratory care program. Failure to do so may be grounds for disciplinary action.

402 West Washington Street, Room W072 Indianapolis, Indiana 46204

Telephone: (317) 234-2054 E-mail: pla8@pla.IN.gov

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