Application for Registered Respiratory Therapist or Certified Respiratory Therapist

Board of Respiratory Care
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasrespiratorycare.gov
Email: info@floridasrespiratorycare.gov
Phone: (850) 245-4373
FAX: (850) 414-6860

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Do Not Write in this Space For Revenue Receipting Only

Applicants are responsible for reading and understanding this application and chapter (ch.) 468, Florida Statutes (F.S.) and Rule 64B32, Florida Administrative Code (F.A.C.), regulating the practice of respiratory care in Florida prior to submission.

Select one application type:

- ☐ **Registered Respiratory Therapist** (RRT) (5701) **$105.00**
- ☐ **Certified Respiratory Therapist** (CRT) (5702) **$105.00**

Total fee of $105.00 includes the following:

Application Fee	$50.00
Licensure Fee	$50.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $55.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent) Do not list your training school's address in this section. Once licensed, this address will display on the internet if a Practice Location address is not provided.

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Practice Location: (Required. If not applicable at the time of application, list N/A.- This address will be posted on the Department of Health's website)

_____ _____
Facility Name Fax Number

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. **SOCIAL SECURITY DISCLOSURE**

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Are you credentialed as a CRT or RRT by the National Board of Respiratory Care (NBRC)? ☐ Yes ☐ No

If "Yes," provide the credentialing date: _____
MM/DD/YYYY

☐ **Applicants who have passed the NBRC exam must contact the NBRC and have an official letter of verification sent to the board office.** The following are **not accepted**: copies of the NBRC passing scores, copy of the credential, or the wallet card. Contact NBRC at www.NBRC.org or by phone at (913) 895-4900.

C. Have you previously applied for licensure in the state of Florida? ☐ Yes ☐ No

If "Yes," provide the following:

Previous Application Date: _____ Application Method: ☐ Exam ☐ Endorsement
MM/DD/YYYY

Were you issued a temporary permit? ☐ Yes ☐ No

D. Do you hold, or have you ever held a temporary permit, license/certification, or other authorization, regardless of status, to practice respiratory care or any health-related profession in any state (including Florida), U.S. territory, or foreign country? ☐ Yes ☐ No

E. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. Online verifications submitted by the applicant are acceptable if they are current and show disciplinary history status.

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. RESPIRATORY EMPLOYMENT HISTORY

List all respiratory related employment in any state including Florida for the previous two-year period, beginning with present or most recent employment. If you **have not** had previous respiratory related employment in any state, write not applicable or N/A. **Do not include clinical/fieldwork experience obtained as part of your education.** (Attach additional sheets if necessary.)

Name & Address of Institution	Dates of Practice: From-To (MM/DD/YYYY)	Title of Position
	to	
	to	
	to	
	to	
	to	

Respiratory related employment is not required for licensure.

Review Rule 64B32-2.001(3)(c), F.A.C., for additional requirements.

☐ Applicants **who have been out of the practice of respiratory care** for two or more years must complete a board-approved comprehensive review course within two years immediately prior to filing the licensure application or be recredentialed in the level in which they are applying to practice. "Board-approved comprehensive course" means any course or courses which include, at a minimum, 14 hours in the topics and numbers of hours listed below.

Topic	Hours
Patient Assessment	3
Hemodynamics	2
Pulmonary Function	1
Arterial Blood Gases	1
Respiratory Equipment	2
Airway Care	1
Mechanical Ventilation	2
Emergency Care/Special Procedures	1
General Respiratory Care (including medication)	1

Name: _____

This information is exempt from public records disclosure.

6. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

7. DISCIPLINE HISTORY

A. Have you ever had a professional healthcare license revoked, suspended, or otherwise acted against, including denial of licensure, by the licensing authority of this state or another state, territory, or country? ☐ Yes ☐ No

B. Have you ever been notified to appear before any licensing authority on a complaint of any nature, including, but not limited to, a charge or violation for unprofessional or unethical conduct? ☐ Yes ☐ No

C. Have you ever been named or sued for malpractice? ☐ Yes ☐ No

D. Have you ever been disciplined, terminated or allowed to resign in lieu of termination, from an employment setting where employed as a Registered/Certified Respiratory Therapist or in any capacity in the health care profession? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

8. CRIMINAL HISTORY

A. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of respiratory care? ☐ Yes ☐ No

B. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

9. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities? ☐ Yes ☐ No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

All documentation must be mailed to:

Board *of* Respiratory Care
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3257

10. STATUS CHANGE FROM CRT TO RRT

If you have a current Florida CRT license and are applying for an RRT license, once you are approved and issued an RRT license, **do you wish to "Voluntarily Relinquish" your CRT license?** ☐ Yes ☐ No

Name: _____

Florida CRTs who become nationally registered and request RRT licensure will be required to submit a new application and fees.

In the state of Florida, **the use of certain titles and abbreviations relative to the practice of respiratory care is allowed only by those individuals who fulfill the requirements of section 468.359, F.S**. Individuals who use any of the protected titles or abbreviations affected by the above section and who are not eligible to do so are in violation of the practice act and may be subject to legal action.

No individual can use the title "Certified Respiratory Therapist" (CRT) or "Registered Respiratory Therapist" (RRT) in Florida if that individual is not licensed as such in Florida, regardless of whether the individual holds national certification. **Individuals who are currently licensed as CRTs in Florida who have obtained national certification may not sign** as an RRT until their licenses have been changed to the registered level. The respiratory therapy application may be downloaded or requested through our website at: http://floridasrespiratorycare.gov/resources.

11. APPLICANT SIGNATURE

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all governmental agencies and instrumentality's (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the department in connection with the processing of this application. I further authorize the department to release to the organizations, individuals, and groups listed above any information for which is material in my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the board's decision concerning my eligibility for examination or licensure. Such supplement is required under ch. 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby acknowledge that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida for the profession for which I am applying. I declare that I am the person referred to in the foregoing application. I further state that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits.

Under penalties of perjury, I declare that I have read the foregoing document, and the evidence presented herein for the purpose of demonstrating, to the satisfaction of the board, that I possess the qualifications preliminary to examination required by s. 486.041 and 486.103, F.S., or that I possess licensure in another state, the district of Columbia, or a territory as required by s. 486.107, F.S., is true.

I hereby acknowledge that practice as a licensed registered or certified respiratory therapist in Florida is governed by ch. 456 and 468, part V, F.S., and ch. 64B32, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to the aforementioned statutes and rules.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

It is recommended that you not accept employment as a Registered/Certified Respiratory Therapist in Florida until you have been issued a license by the Florida Board of Respiratory Care.

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Respiratory Care
4052 Bald Cypress Way Bin C-05
Tallahassee, FL 32399-3257

Board of Respiratory Care License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Respiratory Care.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name * License number * State or jurisdiction of licensure
* Licensure status * Is license in good standing?
* Date of issuance and expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement) If exam, provide exam name, exam level, exam date, and score achieved.
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.