



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

APPLICATION FOR LICENSE AS A RESPIRATORY CARE PRACTITIONER IN THE STATE OF DELAWARE

I am applying for licensure by way of:

- Initial Licensure
- Reinstatement – If you have checked reinstatement, please answer the below question:

Have you been actively engaged in the practice of respiratory care for the past three (3) or more years? Yes No

If no, you are required to give evidence of satisfactory completion of an approved respiratory care examination within two (2) years prior to applying for reinstatement. In addition, you are required to submit proof of completion of 20 hours of continuing education during the two-year period preceding your application.

If yes, you are required to demonstrate proof of active practice satisfactory to the Council and shall demonstrate proof of completion of 20 hours of continuing education during the two-year period preceding the application.

SECTION I: PERSONAL INFORMATION

Name: _____
(Last Name) (First Name) (Middle/Maiden)

Mailing Address: _____
(Street/P.O. Box)

(City) (State) (Zip Code)

Home Telephone: _____ Work Telephone: _____

Email Address: _____ Date of Birth: _____

Social Security Number: _____

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 Del. C. §8735(m). It may be used to enforce child support obligation pursuant to 13 Del. C. §2216 and for other lawful purposes.

SECTION II: EDUCATIONAL INFORMATION

Respiratory Care Practitioner Education:

<u>School</u>	<u>Location</u>	<u>Dates Attended</u>	<u>Degree</u>
_____	_____	_____	_____
_____	_____	_____	_____

SECTION III: LICENSURE / PRACTICE

1. Have you ever sought or been granted a respiratory care practitioner license under another name? Yes No

If yes, indicate other name(s) used:

2. Have you successfully completed the National Board for Respiratory Care, Inc. (NBRC) Entry Level Exam / Certified Respiratory Therapist (CRT) Exam? Yes No

If yes, please have the NBRC provide verification of credentials directly to the Board of Medical Practice.

3. Have you ever been convicted of or entered a plea of guilty or nolo contendere (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? Yes No

If yes, please explain and indicate any other name(s) used:

4. Are there any pending disciplinary actions or complaints against you before any body that regulates the practice of respiratory care? Yes No

If yes, please explain circumstances and outcome:

5. Have you ever had a respiratory care practitioner license denied, revoked, suspended or limited or placed on probation? Yes No

(5. Continued) If yes, please explain circumstances and outcome:

6. Have you ever been granted licensure as a Respiratory Care Practitioner by a State or Territory?

Yes No

If yes, please list the following as indicated below:

State or Territory

License Number

Expiration Date

7. Is this application for licensure based on reciprocity?

Yes No

If yes, on a separate sheet provide a list of the qualifications for licensure from the state which granted the license.

SECTION IV: HEALTH AND DISABILITY

1. Have you recently or within two years had a physical or mental disability which could reasonably be thought to interfere with your practice as a respiratory care practitioner, including use or abuse of dangerous or addicting substances?

Yes No

If yes, please explain on a separate sheet and attach to this application.

2. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?

Yes No

Not applicable

If yes, please explain on a separate sheet and attach to this application.

3. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?

Yes No

Not applicable

If yes, please explain on a separate sheet and attach to this application.

SECTION V: LEGAL AND BEHAVIORAL

1. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes No

If yes, submit a certified copy of your criminal history record.

2. Have you ever been disciplined by a healthcare facility or any entity governing respiratory care licensure? Yes No

If yes, please explain on a separate sheet and attach to this application.

The Board office must receive items submitted for the Board to consider at its meeting no later than two full business days before the meeting. In order to be considered at a Board meeting, license applications must be complete two full business days before the meeting. A complete application is one that includes all required documentation and correct payment.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

SECTION VI: AFFIDAVIT

I, _____, swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; and I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement.

I further understand that by filing this application for a Respiratory Care Practitioner in the State of Delaware, I hereby authorized and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 Delaware Code §1731 or the Rules and Regulations of the Delaware Board of Medical Practice and to determine that I am physically and mentally capable of engaging in the practice of respiratory care with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Practice any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to

