



**NORTH CAROLINA RESPIRATORY CARE BOARD**

1100 Navaho Drive, Suite 242

Raleigh, NC 27609

**APPLICATION FOR CHANGE IN LICENSE STATUS**

**SECTION A - PERSONAL INFORMATION**

License Number: \_\_\_\_\_

Name: \_\_\_\_\_

(Last) (First) (Middle/Maiden)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

(City/County) (State)

Mailing Address: \_\_\_\_\_

(Street/P.O. Box/Route)

\_\_\_\_\_  
(City) (State/County) (Zip Code)

SSN #: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Have you ever been convicted of a felony? Have you ever been convicted of any misdemeanor, except for minor traffic violations? Have you ever been convicted of any crime directly related to the practice of respiratory care? Is any disciplinary action pending or ever been taken against any health care provider license / certificate you have or have had? (If you have already informed the Board of convictions or discipline on your initial application or previous renewal application(s) you may check YES and state that you have already acknowledged the incidents to the Board.)

Yes  No If yes, state details: (Use additional sheet(s) if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION B –REQUESTED CHANGE IN LICENSE CATEGORY**

Provisional License to Active License

Inactive License to Active License

Temporary License to Active License



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**SECTION C – EXAMINATION / EDUCATION:** Applicants requesting a change in license status from Provisional License to Active License must send a Verification Request Form to the National Board for Respiratory Care (NBRC) or request the verification online. (Attachment 1)

Applicants requesting a change in license status from Inactive to Active License must provide evidence of either; (1) Regular practice of respiratory care in another State or Territory of the United States of America or that the applicant is not affected by Article 38 of the General Statutes of North Carolina pursuant to G.S. 90-664(3); or (2) Completion of a minimum of 12 hours of approved continuing education during the prior 12 months of the application for reinstatement, or passage of an NBRC examination during the prior 12 months.

Applicants requesting a change in license status from Temporary License to Active License must verify that all official verification requirements have been sent to the Board. The official documentation requirements include: An official transcript from the applicant's Respiratory Care Program, official verification from the NBRC of the applicant's credentials, and official verification of all licenses the applicant currently holds or has held to practice respiratory care in any jurisdiction(s).

**SECTION D - PRACTICE:** Give the location, full address, phone number and dates of the current employer in which you are actively engaged in the practice of respiratory care. For applicants requesting to change from Inactive to Active status list the facility at which you plan to practice after issuance of an Active license.

Facility	Address	Phone Number	Dates
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**SECTION E – CONTINUING EDUCATION:** Provide the course names, date(s), provider, the course approval number and the number of hours of all Board approved Respiratory Care Continuing Education courses completed during the past 12 months. If you took and passed an NBRC examination within the past 12 months, a notation of the examination taken with the date taken must be noted below. Use additional sheets if needed and attach them to the application.

Course Name	Date(s)	Provider	Course Approval Number	CE Hours
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**SECTION F - AFFIDAVIT (The application must be notarized.)**

(All applicants must complete this section.)

STATE OF \_\_\_\_\_ )  
 ) ss  
COUNTY OF \_\_\_\_\_ )

I, \_\_\_\_\_, declare that I am the person referred to in this application and that the statements herein are true and complete. I declare that I have read and understand the Respiratory Care Practice Act and the Board Rules. I declare that I am currently certified by the American Heart Association (BLS for Healthcare Provider) or the American Red Cross (CPR/AED for the Professional Rescuer) or the American Safety and Health Institute (CPR/AED for the Professional Rescuer) and that I will maintain certification. (Attach a copy, front and back, of your current BLS or Professional Rescuer card). I understand that state law requires me to provide to the Board within 30 days any change of name and change of residence and/or business address.

\_\_\_\_\_  
(Signature of Applicant)

Sworn before me this \_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

(Seal)

My Commission Expires:\_\_\_\_\_

**FEES: \$125.00** fee for a change in license status from Temporary License or Provisional License to Active License.

**\$65.00** fee for a change in license status from Inactive License to Active License. Note: License expiration date does not change.

The fees must be payable to the North Carolina Respiratory Care Board by **Cashier's Check, Certified Check or Money Order.**

Mail Application and attachments to the North Carolina Respiratory Care Board.



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## REQUEST FOR VERIFICATION OF CREDENTIALS

TO APPLICANT: Complete Section 1 below and submit it, along with the required \$5 fee for active NBRC members and \$20 fee for inactive members, to:

NBRC Executive Office  
18000 W. 105<sup>th</sup> Street  
Olathe, KS 66061-7543

You may also request and pay for the verification online at: <http://www.nbrc.org>. Online verification will decrease the time needed for the NBRC to supply credential verification to the NCRCB.

### SECTION 1:

I am applying for state licensure in North Carolina and I am requesting the NBRC to verify my respiratory care credential(s) directly to the North Carolina Respiratory Care Board.

I hold the following NBRC credentials:  CRT  RRT

PRINT NAME UNDER WHICH YOU WERE CREDENTIALIALED:

\_\_\_\_\_

Last	First	Middle Initial	Former Name
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PRINT APPLICANT FULL NAME AND CURRENT ADDRESS:

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number

\_\_\_\_\_

Last	First	Middle Initial	Former Name
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\_\_\_\_\_

Street /Apt. #

\_\_\_\_\_

City	State	Zip Code
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\_\_\_\_\_

Business Phone	Home Phone
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Signature	Date
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ATTACHMENT 1