



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)

Physical Address (If different from your mailing address):

_____ (House Number / Street)

_____ (City) (State/County) (Zip Code)

SSN #: _____ Telephone: (____) _____

Email Address: _____

SECTION B –REQUESTED CHANGE IN LICENSE CATEGORY

Provisional License to Active License

Inactive License to Active License

Temporary License to Active License

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

\$75.00 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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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 – PERSONAL BACKGROUND

Name Printed: _____

Please check the appropriate box to answer each of the following questions, and you should include in each of your responses all information relating to events in North Carolina, or in any U.S. State or Territory, or in any other country or territory worldwide. Except where otherwise indicated, your responses must include all circumstances during your entire life.

Your application must be current and complete as of the date that you sign it and have it notarized, but you also are required to update your responses to report additional information relating to any of these questions that you recall or which occurs after you sign your application.

For each YES response, provide a detailed description that will be sufficient for the Board to understand all of the details of each circumstance, and please remember that you also may be invited to attend an interview with the Board's Investigation and Informal Settlement Committee before the Board takes action on your application.

1. Are you aware of any situation within the past 10 years in which there has been a complaint or investigation or action, relating to your conduct or professional competence that has been received or conducted by any of the following agencies or organizations:

- Any professional licensing board or agency Yes No
- Any medical or professional organization/association Yes No
- Any local, state, federal, or other governmental agency Yes No
- Any private or governmental insurance company or payor Yes No
- Any professional liability insurance carrier Yes No
- Any hospital or other healthcare organization Yes No
- Any professional school or training program Yes No
- Any professional certifying board Yes No
- Any military service organization Yes No

2. Yes No **Has there been any occasion, EVER, AT ANY TIME IN THE PAST,** when a professional licensing board, agency, or any other organization that provides professional certification or credentialing denied you the privilege of taking an examination to receive professional certification or credentialing? **[NOTE: YOUR RESPONSE SHOULD ALSO INCLUDE BOARDS, AGENCIES AND ORGANIZATIONS THAT CERTIFY OR CREDENTIAL NON-HEALTH CARE PROFESSIONS AND OCCUPATIONS.]**

3. Yes No **Has there EVER, AT ANY TIME IN THE PAST,** been an occasion when you surrendered or were denied a license by a professional certification or credentialing licensing board, agency, or any other organization (including agencies and organizations that issue non-health care professional certification or credentialing)?

4. Yes No **Has there EVER, AT ANY TIME IN THE PAST,** been an occasion when you were issued a restricted or limited license by a professional certification or credentialing licensing board, agency, or any other organization (including agencies and organizations that issue non-health care professional certification or credentialing)?



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5. **Yes** **No** **In the past five (5) years**, have you used or consumed any illicit or illegal drugs including, but not limited to cocaine, heroin, ecstasy, LSD, mescaline, psilocybin, PCP and/or marijuana? If you answer yes to this question, please note in your detailed response any details about your participation in any rehabilitation program, including the results of any testing that you have participated in as part of such a program.
6. **Yes** **No** **In the past five (5) years**, have you used or consumed any controlled substance or other prescription drug that you obtained through illegal or improper means? If you answer yes to this question, please note in your detailed response any details about your participation in any rehabilitation program, including the results of any testing that you have participated in as part of such a program.
7. **Yes** **No** **In the past five (5) years**, have you used alcohol or other substances in a manner that could in any way impair or limit your ability to practice respiratory care with reasonable skill and safety, or have you been told you were impaired by your use of alcohol or other substances in a manner that could impair or limit your ability to practice respiratory care with reasonable skill and safety? If you answer yes to this question, please note in your detailed response any details about your participation in any rehabilitation program, including the results of any testing that you have participated in as part of such a program.
8. **Yes** **No** **In the past ten (10) years**, have you had, or have you been told you have, a mental health or physical condition (not referenced above) which in any way limits or impairs or, if untreated, could limit or impair your ability to practice respiratory care in a competent or professional manner? If you answer yes to this question, please note in your detailed response if you have gone through a treatment program for any such condition.
9. **Yes** **No** **Have you in the past ten (10) years been convicted of a misdemeanor?**

Note: You are not required to report minor traffic offenses. "Minor traffic offenses" **do not** include driving while intoxicated, driving under the influence, careless and reckless driving, or any offense involving serious injury or death.

Convicted includes if you pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere (no contest) or received a prayer for judgment continued (PJC) for a violation of federal, state, or local law.

10. **Yes** **No** **Have you EVER, AT ANY TIME IN THE PAST, been convicted of a felony?**

Convicted includes if you pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere (no contest), or received a prayer for judgment continued (PJC) for a violation of federal, state or local law.



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SECTION F - AFFIDAVIT (The application must be notarized.)

THIS STATEMENT MUST BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC

I certify and acknowledge the following (initial each statement in the presence of a Notary Public):

_____ I am the person named in the various forms and credentials furnished with respect to my application and that all documents, forms or copies furnished with respect to my application are true in every aspect. If I fail to answer questions truthfully and completely, the NCRCB may deny my application or take other disciplinary action and that all license denials are reported to the National Practitioners Data Bank and other state boards.

_____ If I am in doubt about whether to report any information requested, I should fully disclose the information and provide an explanation of the circumstances.

_____ If someone else completed the application for me, I am responsible to make sure the answers are truthful and complete.

_____ I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the NCRCB any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit the NCRCB or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

_____ I hereby release, discharge and exonerate the NCRCB, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the NCRCB.

_____ I certify that I have read and understand the Respiratory Care Practice Act and the Board Rules. I certify 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. (Enclose 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 practice site address.



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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. 105th 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 CREDENTIALALED:

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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