ATTENTION!

Effective October 1, 2016 Criminal History Record Checks (CHRC) will be required for all applicants applying for a license in Maryland.

Please do not submit your application for licensure until after you have submitted your fingerprints for a CHRC.

For detailed instructions on submitting your fingerprints for a CHRC, please read and follow the attached instructions.
Notice: Criminal History Records Check
Effective October 1, 2016

Dear Applicant:

Effective October 1, 2016, a full Criminal History Records Check (CHRC) will be a qualification of licensure and a requirement for all Maryland Board of Physicians (Board) licensees. The Board may not issue a new license, renew or reinstate an existing license of any applicant, physician or allied health practitioner if criminal history record information has not been received.

A CHRC will include both a State and national criminal history records check conducted by the Maryland Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS). An applicant for initial licensure, renewal or reinstatement shall apply to CJIS for a CHRC and the application shall include:

1. Two complete sets of legible fingerprints taken on forms approved by CJIS and the FBI; and
2. Payment of the required fees.

Fingerprints

A. For Initial Applicants and Reinstatements

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to get fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/ Certification

1. Within Maryland
   a. Go to an authorized location to get fingerprinted prior to mailing in your application to the Board. For a list of Electronic fingerprinting locations go to the following website: http://www.dpscs.state.md.us/publicservs/fingerprint.shtml. The Board is not responsible for the list. If there are any concerns about a fingerprinting location please contact CJIS directly.
   b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # provided on page 1 of this letter.
   c. Pay the appropriate fee to the fingerprinting entity.

Once the results of the CHRCs are received at the Board, the application process will be completed in accordance to Board regulations and policies.
2. **Outside of Maryland**
   a. Out of state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
   b. Either:
      i. Write to CJIS-Central Repository at P.O Box 32708, Pikesville, Maryland 21282-2708, or
      ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request fingerprint cards.
   c. Have CJIS Authorization and FBI ORI Board #’s available to complete your submission.
   d. Mail the fingerprint card and associated fee to CJIS-Central Repository, P.O Box 32708, Pikesville, Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
   e. Please include a check or money order made out to “CJIS Central Repository”.

Once the results of the CHRCs are received at the Board, the application process will be completed in accordance to the Board regulations and policies.

B. **For Renewal Applicants**

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to get fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/Certification

3. **Within Maryland**

a. Go to an authorized location to get fingerprinted prior to mailing in your application to the Board. For a list of Electronic fingerprinting locations go to the following website: http://www.dpscs.state.md.us/publicservs/fingerprint.shtml. The Board is not responsible for the list. If there are any concerns about a fingerprinting location please contact CJIS directly.

b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # referenced on page 1 of this letter.

c. Pay the appropriate fee to the fingerprinting entity.

Once the results of the CHRCs are received at the Board, the application process will be completed in accordance to Board regulations and policies.

**PLEASE BE ADVISED:** If the Board is not in receipt of the CHRC, online automatic renewal will be BLOCKED. You will be unable to renew the license.
4. **Outside of Maryland**
   a. Out of state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
   b. Either:
      i. Write to CJIS-Central Repository at P.O Box 32708, Pikesville, Maryland 21282-2708, or
      ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request fingerprint cards.
   c. Have CJIS Authorization and FBI ORI Board #'s available to complete your submission.
   d. Mail the fingerprint card and associated fee to CJIS-Central Repository, P.O Box 32708, Pikesville, Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
   e. Please include a check or money order made out to “CJIS Central Repository”.

Once the results of the CHRCs are received at the Board, the application process will be completed in accordance to the Board regulations and policies.

**PLEASE BE ADVISED:** If the Board is not in receipt of the CHRC, the online automatic renewal will be BLOCKED. You will be unable to renew the license.

**Fees:**

Fees are required for CJIS to process each criminal background record check request. All fees must be paid by credit card, check or money order in United States currency. The Central Repository cannot accept cash.

The total fee is $ 52.75 ($32.75 background check and $20.00 fingerprinting service) if done by CJIS. However, the cost of fingerprinting services from private providers may vary. The fingerprinting fee must be paid directly to the fingerprinting entity.

Do not send any payment to the Board, as it does not conduct CHRCs. For additional information contact CJIS at 410-764-4501 or visit [http://www.dpscs.state.md.us/publicservs/fingerprint.shtml](http://www.dpscs.state.md.us/publicservs/fingerprint.shtml).

**Questions?**

Should you have any questions, concerns, or to check the status of a criminal history record information request, please contact the **CJIS Call Center at 410-764-4501 or 1-888-795-0011**, Monday-Friday 8:00 a.m. - 5:00 p.m. The Board cannot assist you in this regard.

*Please do not contact the Board to verify receipt or submit receipts. The Board receives electronic CHRC notifications within 72 hours.*
Dear Applicant:

Attached is an application packet for licensure as a Respiratory Care Practitioner in Maryland. The application fee is $200.00 and is non-refundable. Please make your check or money order payable to: Maryland Board of Physicians. Mail your application and check to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Please DO NOT mail or hand deliver your application to the Board office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.

Applications are processed in order of receipt. Please allow at least 3 to 6 weeks for the processing of your application. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Please do not continuously call your analyst to check on the status of your application. Constant interruptions slow down the process. Generally, within 5 - 7 business days from the receipt of your application, your analyst will contact you if additional documentation is required. Please make sure your contact information is current.

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school. Verification of national certification must come from the national certifying body and verification of other licenses must come from the state board that issued your license.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 7 of the application or provided documentation allowing staff to disclose the status to another party. Other parties include family members, friends and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120 day period. The Board does not grant exemptions from these requirements. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

The Board’s website is updated every 24 hours. You may wish to check the website at www.mbp.state.md.us before calling the Board to find out if a license was issued to you. When you get to the website, click Search Practitioner Profiles.

We look forward to receiving your completed application and will process it as quickly as possible.

The Allied Health Division
Maryland Board of Physicians
APPLICATION FOR LICENSURE OF RESPIRATORY CARE PRACTITIONERS

INSTRUCTIONS AND IMPORTANT INFORMATION

If you have been previously licensed in Maryland as a respiratory care practitioner, DO NOT USE THIS APPLICATION. Download a copy of the reinstatement application from the Board’s website at www.mbp.state.md.us or call the number listed above and request a reinstatement application.

1. **Name:** If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

2. **Non-Public Address:** The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.

3. **Public Address:** The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

4. **Contact Information (Telephones and E-mail Address):** The Board will contact you using the information provided.

5. **Date of Birth:** Health Occupations Article §15-303(a)(3), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.

6. **Gender:** Disclosure of Gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity:** Disclosure of race or ethnicity is not requirements of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number:** Maryland law requires the Board of Physicians to collect Social Security numbers from all persons applying for professional licenses or certificates. Disclosure of your Social Security number is mandatory. The Maryland Board of Physicians is permitted by State or Federal law or regulation to use the Social Security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);  
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);  
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);  
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).
9. **Employment Activities:** Please complete and include all employment history beginning with the date you graduated from an accredited Respiratory Therapy educational program.

10. **Verification of Professional Education:** Complete the top portion of the Verification of Professional Education form (RCP 1) and forward it to the CoARC or CAAHEP accredited respiratory therapy program from which you graduated.

    If your school/program is no longer in existence, please either contact the Board of Higher Education or the Board of Education in the state where you attended the program. You may obtain the contact information by accessing [www.statelocalgov.net/50states-education.cfm](http://www.statelocalgov.net/50states-education.cfm).

    You may also wish to contact the Commission on Accreditation of Allied Health Education Programs (CAAHEP) at [www.caahep.org](http://www.caahep.org) or the Committee on Accreditation for Respiratory Care (CoARC) at [www.coarc.org](http://www.coarc.org). These agencies accredit respiratory care programs and may have information on closed schools/programs.

11. **National Certification:** Verification of certification from the National Board of Respiratory Care (NBRC). Applicants for licensure as a respiratory care practitioner must be currently certified by NBRC.

12. **Oral and Written Competency in English:** Demonstrate verbal and written competency in the English language by:

    a. Graduation from an English-speaking high school, undergraduate school, or professional school; **OR**

    Provide evidence that you achieved a passing score on both the Test of Spoken English (TSE) **and** the Test of English as Foreign Language (TOEFL).

    b. Achieve a passing score of at least 220 on the TSE **and** at least 550 TOEFL Paper and Pencil examination taken before July 1995; **OR**

    c. Achieve a passing score of at least 50 on the TSE **and** at least 213 on the TOEFL Computer-based exam Beginning July 1995; **OR**

    d. Achieve a passing score of at least 26 on the spoken part **and** 79 on the written part of the TOEFL.

13. **Licensure in Other States:** If you have ever held a license, certification or registration to practice as a respiratory therapist in any state or jurisdiction or in ANY other health care profession in any other states, including Maryland, complete the top portion of the Verification of Other State Licenses form (RCP 2) and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians in another profession, you do not need to complete the RCP 2 form.

14. **Character and Fitness Questions:** Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation of a “Yes” response and the required supporting documentation will delay the review process.
15. **Release**: Sign and date the certification. You are giving the Board and Respiratory Care Professional Standards Committee permission to request additional information to support your application for licensure.

16. **Optional Third Party Release**: If you wish the Board to release your information to a third party, complete the third party release statement.

17. **Cooperation in an Investigation**: You may be asked to cooperate fully with any request for information related to your practice as a Respiratory Care Practitioner.

18. **Certification and Passport Quality Photo**: Sign and date the certification in the presence of a notary public after you have affixed a recent passport quality (2” x 2”) photo to the application in the space provided.

**Supplemental Forms RCP 1 and RCP 2 - Verification of Education (RCP 1)**: Complete this form and send it to the institutions where you completed your CoARC or CAAHEP accredited educational program.

**Verification of Other State Licenses (RCP 2)**: Complete this form if you were issued a license/certification/registration as a respiratory therapist or ANY other health care provider.

**Licensure and Renewal**: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on May 30th of the first even year following the date on which you are initially licensed. You will have to renew your license if you plan to continue practicing in Maryland. The renewal notice will be sent at least 30 - 60 days prior to the expiration of your license to the most current address on file with the Board. **You will be required to renew your license on-line by May 30th of every even year whether or not you receive the renewal notice.**

**PRACTICING RESPIRATORY CARE**: A person may not practice, attempt to practice, or offer to practice respiratory care in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides respiratory care unless the person is licensed to practice by the Board.

The Maryland Board of Physicians supports the Americans with Disabilities Act and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board ADA designee, Ellen Douglas Smith at (410)764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board's compliance with the ADA, please contact Ms. Smith.

**Please keep a copy of your application.**
ATTENTION

If You Are a Veteran, Service Member or Military Spouse

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

☐ Service Member — Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. Provide supporting documentation.

☐ Veteran — Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. Provide supporting documentation.

☐ Military Spouse: Check the appropriate box

☐ Spouse is a Veteran. Provide supporting documentation.

☐ Spouse was a service member who died within one year before the date of submitting the application. Provide supporting documentation.

☐ Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. Provide supporting documentation.

Name of Applicant (PRINT) __________________________________________________________

Military Branch ________________________________________________________________

“Veteran” means a former service member who was discharged from active duty under circumstances other than dishonorable within one year before the date on which the application for license, certificate, or registration is submitted.

“Veteran” does not include an individual who has completed active duty and has been discharged for more than one year before the application for a license, certification, or registration is submitted.

“Military Spouse” means the spouse of a service member or veteran,

“Military Spouse” includes a surviving spouse of:

* A veteran; or

* A service member who died within one year before the date on which the application for license, certification, or registration is submitted.

“Service Member” means an individual who is an active duty member of:

* The Armed Forces of The United States

* A reserve component of the Armed Forces of the United States; or

* The National Guards of any state
Please print legibly or type the required information. Do not leave any item unanswered.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.
   - Last name and generational indicator (Jr., Sr., II, III, etc.):
   - First name and middle name:
   (If applicable, please check a box and complete below)
   - Complete Maiden Name
   - Complete Former Name

   Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.
   - Street Address: **(Do NOT use a P. O. Box)**
   - City
   - State
   - Zip Code

3. **Public Address:** Your public address of record. This address, usually your place of employment, is available to the public and will be posted on the Internet.
   - Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**
   - City
   - State
   - Zip Code

4. **Telephone(s):**
   - Home:
   - Office:
   - Cell/Pager:

5. **Date of Birth:**
   - Month
   - Day
   - Year

6. **Gender:**
   - Male
   - Female

7. **Race:** Check all that apply
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or other Pacific Islander
   - White

   **Ethnicity:**
   - Hispanic or Latino
   - Not Hispanic or Latino

8. **Social Security Number:**
   - 

For Board Use Only

- License Number:
- School Code:
- Date Issued:
- Expiration Date:
- Licensed By:
9. Chronology of Employment Activities: Beginning with the date you completed your Respiratory Therapy Program, list employment activities as a respiratory therapist. Also list any other health-related employment. Explain any lapse over 1 year in which you were not employed. Please write N/A below if the statements do not apply to you. Please copy this page if you need more space. Sign and date all additional pages.

Graduation Date from CRT/RRT Program:  
Month: _______ Year: ________

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<th>Year</th>
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CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.
Chronology (Cont’d)  Please photocopy this page if more space is needed. Sign and date all additional pages.

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<th>Month Year TO Month Year</th>
<th>Activity/Position:</th>
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Name and telephone of Supervisor: Name and Address of Employer:
10. EDUCATIONAL PROGRAM: Please complete this section and send the attached Verification of Professional Education (RCP 1) to your Respiratory Therapy program.

Name of School/Program

/       /       
Graduation Date

Degree and Type (Certificate, Associates, etc.)

Street Address

City State Zip Code

Telephone Number, including area code

11. National Certification: List the date and certification number.

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<tr>
<th>NBRC Designation</th>
<th>Certification #</th>
<th>Certification Date</th>
<th>Expiration Date</th>
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<td>☐ RRT</td>
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12. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

☐ I graduated from a recognized English-speaking professional school; OR

☐ I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment; OR

I achieved a passing score of at least:

☐ 220 on the TSE and at least 550 TOEFL Paper and Pencil examination taken before July 1995; OR

☐ 50 on the TSE and at least 213 on the TOEFL Computer-based exam beginning July 1995; OR.

☐ 26 on the spoken part and 79-80 on the written part of the TOEFL.
13 a. Licensure as a Respiratory Therapist. List all states or other jurisdictions in which ever held a license/certificate/registration to practice as a Respiratory Therapist. Please complete and mail the attached Verification of Other State Licenses form (RCP 2) to the appropriate state board(s). If you have never been licensed as a Respiratory Therapist, write N/A here _____________________.

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<thead>
<tr>
<th>State</th>
<th>License #</th>
<th>Category (CRT/RRT)</th>
<th>Year Issued</th>
<th>Expiration Date</th>
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13 b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license/certificate/registration to practice in ANY other health occupation. Please complete and mail the attached Verification of Other State License(s) form (RCP 2) to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here ______________________________.

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<th>State</th>
<th>License #</th>
<th>Category (EMT; Nurse, etc)</th>
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14. Character and Fitness Questions (Check either YES or NO)

YES  NO

a. □ □ Have you ever been denied a license, certification or registration to practice any health occupation? (ex: state board orders and/or charges; adverse or disciplinary actions in any healthcare facility)

b. □ □ Has any State licensing or disciplinary board or comparable body in the Armed Services taken any action against your license, certification or registration including but not limited to reprimand, suspension, or revocation? (ex: state board orders and/or charges; adverse or disciplinary actions)

c. □ □ Have you surrendered or failed to renew a license, certification or registration in any State to avoid any disciplinary action? (ex: state board orders and/or charges; adverse or disciplinary actions)

d. □ □ Has your employment by any health care employer been affected by disciplinary actions including probation, suspension, loss of privileges, transfer to other duties, or termination of employment or contract? (ex: provide name of institution, correspondence received or sent, related documents.)

e. □ □ Have you ever been charged with or convicted of any criminal act for which you pled nolo contendere, could receive, or did receive, probation before judgment, or were sentenced to probation or confinement? (ex: police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)

f. □ □ Have you ever been convicted or received probation before judgment for driving while intoxicated or impaired? (ex: police reports; court orders or judgments; orders of probation; certificates and/or letters of completion of any mandatory program(s), termination of probation, orders of dismissal, orders of expungement)

g. □ □ Do you currently have a physical or mental condition which may affect your ability to practice your profession? (ex: medical evaluations)

h. □ □ Has any malpractice or claim for damages been filed against you which is pending, has been dismissed, has been settled, or damages have been awarded against you? (ex: malpractice claims)

i. □ □ Have you ever been discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, type of discharge. (ex: DD214)

j. □ □ Are there any outstanding charges pending against you in any jurisdiction, including any State licensing or disciplinary Board or comparable body in the Armed Services for violation of any law relative to the practice of any health occupation? (ex: copy of charges)

>>> If you answered “YES” to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Examples of documentation is next to the question. Please note that these examples are not all inclusive. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.
15. Release: I agree that the Maryland Board of Physicians (the Board) and the Respiratory Care Professional Standards Committee may request any information necessary to process my application for initial licensure as a Respiratory Care Practitioner in Maryland from any person or agency, including but not limited to the NBRC, former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Applicant’s Name (Printed) ____________________________  Applicant’s Signature ____________________________  Date ____________

16. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

The Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: ____________________________  Applicant’s Signature ____________________________  Date ____________

Phone: ____________________________

17. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed Respiratory Care Practitioner in Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-5A-14.

Applicant’s Signature ____________________________  Date ____________

18. Certification: To be completed by the applicant in the presence of a notary public after the applicant’s picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 14-5A-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.11 which govern the practice of Respiratory Care Practitioners in Maryland.

Applicant’s Signature ____________________________  Date ____________

STATE OF ____________________________  CITY/COUNTY OF ____________________________

I HEREBY CERTIFY that on this _______________ day of ____________________________ , 20 _______ , before me, ____________________________ , a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, ____________________________ whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law that signing the foregoing application was his/her voluntary act and deed.

AS WITNESS my hand and notarial seal. ____________________________

Notary Public ____________________________

My Commission expires: ____________________________

APPLICANT: ____________________________

PASTE YOUR PASSPORT-QUALITY PHOTO HERE BEFORE NOTARIZING

STOP! Completed application and check for $200 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

DON'T FORGET TO KEEP A COPY OF YOUR APPLICATION!
Respiratory Care Practitioners

Supplemental Forms

RCP 1—Verification of Professional Education (Accredited CRT/RRT Educational Program)

RCP 2—Verification of Other State Licenses
Part 1
APPLICANT: Complete Part 1 and send to the institution where you completed your Respiratory Therapy program.

Name: ____________________________________________

Last name and generational indicator (Jr., Sr., II, III, etc.)       First name       Middle name       Maiden Name

Date of Birth: ________/__________/_______

Social Security Number: ____________- _________ - ______________

Professional School of Graduation: __________________________________________

Attended from: ____________________________ to ____________________________

Date of Graduation: ____________________________   Degree Received: ____________________________

Applicant's Signature: ____________________________       Date: ____________________________

Part 2
REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: ____________________________

Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☒ Associate’s Degree       ☑ Certificate       ☐ Bachelor’s Degree       ☐ Master’s Degree       ☐ Other: ____________________________ (specify)

in ____________________________ .   The program was accredited by: ____________________________

Educational Program       CoARC, CAAHEP, CAHEA, etc.

Printed Name of Authorized Official       Name of Institution

Title of Authorized Official       Telephone Number       Fax Number

Signature of Authorized Official       Date
## VERIFICATION OF OTHER STATE LICENSES

### Part 1
**APPLICANT:** Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license/certificate/registration to practice as a Respiratory Therapist. Also send use this form to send to each state board, including Maryland, that ever issued you a license/certification/registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

<table>
<thead>
<tr>
<th>License Type:</th>
<th>License Number:</th>
<th>State of Licensure:</th>
<th>Expiration Date:</th>
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</table>

**Name:** _______________________________________________________________________________________________________________

(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No.: __________ Date of Birth: ________ / ________ / ________

Professional School of Graduation: ________________________________________ Year: __________

Signature: ___________________________ Date: __________

### Part 2
**AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD:** Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

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<tr>
<th>State Board</th>
<th>Seal</th>
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<table>
<thead>
<tr>
<th>License number</th>
<th>Date Issued</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

Is/was the license in good standing? [ ] Yes [ ] No

If not in good standing is/was it: [ ] reprimanded [ ] suspended [ ] revoked [ ] surrendered

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? [ ] Yes [ ] No

If yes, please explain: ____________________________________________________________________________________________

Other Derogatory Information or Pending Charges: __________________________________________________________________________

Printed Name of Authorized Official: ___________________________ Direct Telephone Number: ___________________________

Title of Authorized Official: ___________________________ Printed Name of State: ___________________________

Signature of Authorized Official: ___________________________ Date: __________

State Board Seal