



**S.C. Department of Labor, Licensing and Regulation  
Board of Medical Examiners**

110 Centerview Drive, Suite 202  
Post Office Box 11289  
Columbia SC 29211-1289  
(803) 896-4500

**APPLICATION FOR A LICENSE TO PRACTICE  
AS A RESPIRATORY CARE PRACTITIONER**

**IMPORTANT:** Read the enclosed requirements carefully before completing application. Appropriate fee must accompany application; **application fee is non-refundable.** *The application form itself is a public document obtainable under the Freedom of Information Act.*

I hereby make application for a license to practice as a respiratory care practitioner in the State of South Carolina and submit the following statements of facts with the required supporting documents:

(Please type or print clearly)

Applicant's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
City State Zip

Home Phone: ( ) \_\_\_\_\_

S.C. Medical Director: \_\_\_\_\_

Place of Employment in South Carolina: \_\_\_\_\_

Street  
City State Zip

Business Phone ( ) \_\_\_\_\_

\*Social Security No.: \_\_\_\_\_

The SSN is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner DataBank (NPDB), among other things.

CONTROL # \_\_\_\_\_

CHECK # \_\_\_\_\_

AMOUNT \$ \_\_\_\_\_

## I. PERSONAL DATA

Answer Yes or No

1. Has your Respiratory Care Practitioner certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? \_\_\_\_\_
2. Have you ever had an application to practice as a Respiratory Care Practitioner denied or refused by another licensing board or entity? \_\_\_\_\_
3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? \_\_\_\_\_
4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? \_\_\_\_\_
5. Are you currently under any investigation or the subject of pending disciplinary action by any licensing board or other entity? \_\_\_\_\_
6. Is your Respiratory Care Practitioner's certificate/license currently restricted in any way by any medical licensing board, health care facility or other entity? \_\_\_\_\_
7. Currently or within the last ten years, have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? \_\_\_\_\_
8. Has your ability to practice as a Respiratory Care Practitioner ever been impaired by any physical or mental illness or by the use of alcohol or drugs? \_\_\_\_\_
9. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? \_\_\_\_\_
10. Have you ever discontinued practicing as a Respiratory Care Practitioner for any reason for one month or more? \_\_\_\_\_
11. Have you ever been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state or local law (other than a minor traffic violation)? \_\_\_\_\_
12. Have you ever been known by any other name or surname? \_\_\_\_\_
13. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license? \_\_\_\_\_
14. Have you ever been discharged involuntarily from employment? If so, give full details. \_\_\_\_\_

**NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.**

## II. EDUCATION

Attach copies of diplomas, degrees and certificates of training.

<b>School attended Name and Address</b>	<b>Dates Attended From (Mo./Yr.) to (Mo./Yr.)</b>	<b>Diploma or Degree Received</b>
<b>High School:</b>		
<b>College:</b>		
<b>Respiratory Therapy Training:</b>		
<b>Graduate School:</b>		

## III. PROFESSIONAL INFORMATION

List all states in which you are licensed or certified to practice as a respiratory care practitioner (active/inactive).

<b>State</b>	<b>License/Certificate Number</b>	<b>Date Issued</b>	<b>Basis of Licensure/Certification</b>	<b>Status (Active/Inactive)</b>

### III. PROFESSIONAL INFORMATION

(Continued)

1. Have you taken the entry level or higher level National Board for Respiratory Care, Inc. Examination?  
\_\_\_\_\_ If so, please specify date and examination taken and whether you passed or failed.  
\_\_\_\_\_ If registered, give your registry number\_\_\_\_\_.  
A copy of your CRTT or RRT National Board certificate or examination results must be included with this application. Verification directly from NBRC may be required if appropriate documentation is not provided. Provide written explanation if certificate is not attached.
2. Have you ever taken any other state or national examination(s) in respiratory therapy? \_\_\_\_\_  
If so, give the date(s), location and name of examination(s) taken, and indicate whether you passed or failed.
3. Do you plan to care for cardio-pulmonary patients in a home care setting? \_\_\_\_\_ If yes, you must attach a statement signed by your physician sponsor detailing the duties that you will perform and the type of supervision you will receive in performing these duties.

### IV. EMPLOYMENT HISTORY

In chronological order (most recent first), list all employment relevant to training and/or work experience in respiratory therapy since graduating from your respiratory care program.

<b>Place of Employment</b> (Name of Company, City and State)	<b>Dates of Employment</b>	<b>Title and Job Description</b>

(Attach additional sheet of paper is needed)

#### IV. REFERENCES

(Theses persons should not be related to you by blood or marriage.) The references listed must be more than a casual acquaintance and of a substantial duration but need not be a respiratory care practitioner.

**Please have statements from your references as to your moral character and fitness forwarded to the Board office on the enclosed Board form.**

Name	Street or Mailing Address	Occupation
1.		
2.		
3.		

#### VI. AFFIDAVIT

I, \_\_\_\_\_ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as a Respiratory Care Practitioner in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as a Respiratory Care Practitioner in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards and to federal and state entities, as required by law.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public Signature: \_\_\_\_\_ (L.S.) For: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_ **Page 5 of 6**

THIS SPACE FOR OFFICE USE ONLY

APPLICATION FOR  
RESPIRATORY CARE PRACTITIONER  
LICENSURE

Issued by the

South Carolina Department of Labor, Licensing  
and Regulations  
Board of Medical Examiners  
110 Centerview Drive  
Suite 202  
Post Office Box 11289  
Columbia, South Carolina 29211-1289  
(803) 896-4500

**NOTE:** A recent portrait type photograph  
must be pasted here. Photograph must be  
passport size or snap shot.

Approved by Board /Committee Member:

**GENERAL INFORMATION**

\_\_\_\_\_  
Board/Committee Member Signature

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

\_\_\_\_\_  
Date Approved

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

Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**PHOTOGRAPH**

SC Department of Labor, Licensing and Regulation  
**Board of Medical Examiners**  
Post Office Box 11289  
Columbia, SC 29211-1289  
(803) 896-4500  
(803) 896-4515 Fax

**REQUIREMENTS FOR A LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER**

READ REQUIREMENTS CAREFULLY BEFORE COMPLETING APPLICATION.

**I. GENERAL INFORMATION**

The term Respiratory Care Practitioner encompasses both respiratory therapists and respiratory therapy technicians. Section 40-47-510 (5)

**II. REQUIREMENTS FOR LICENSURE**

In order to qualify for a license as a respiratory care practitioner the applicant must file a written application on forms provided by the Board and must show that he/she meets the following requirements (Section 40-47-600):

- (a) good moral character;
- (b) passage of the entry level examination given by the National Board for Respiratory Care, Inc., or other examination that may be approved.

**III. FEES (Application fee is non-refundable)**

The application fee for permanent licensure is \$134.

**IV. APPLICATION FORM**

The application form is self-explanatory. It sets forth the required supporting documents and/or information that must be submitted with your application. The Board **will not** consider an applicant for licensure until a complete application along with appropriate fee is submitted.

An application will be considered as incomplete until all of the following information is submitted:

- (a) all questions on the application answered fully;
- (b) all supporting documents and/or information required by application form received;
- (c) National Board examination results received;
- (d) State licenses/certificates verified;
- (e) application fee submitted.

**V. PROCESSING TIME**

Applications having all information with no identifiable problems will be expeditiously processed. Incomplete applications or problematic applications will require additional processing time.

**POLICY OF THE BOARD REQUIRES INDIVIDUALS WHO HAVE NOT ACTIVELY PRACTICED RESPIRATORY CARE FOR FIVE (5) YEARS OR MORE TO TAKE AND PASS THE NBRC-ENTRY LEVEL EXAMINATION. PROOF OF PASSAGE MUST BE PROVIDED TO THE BOARD BEFORE YOUR LICENSE WILL BE ISSUED.**

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**REFERENCE FOR RESPIRATORY CARE PRACTITIONER APPLICANT**

- Make copies of this form and provide to each reference
- Type or print clearly
- Individuals giving a reference cannot be related by blood or marriage

**Applicant's Name:** \_\_\_\_\_

Dates of Association: \_\_\_\_\_

Relation to Applicant: \_\_\_\_\_

Describe the applicant's moral character and fitness (attach a separate sheet of paper if necessary)

**Moral Character:** \_\_\_\_\_

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**Professional Competence:** \_\_\_\_\_

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**Interpersonal Relations with Others:** \_\_\_\_\_

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Name (Print) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Telephone Number (during business hours) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Respiratory Care Verification of Licensure/Certification**

Complete top portion and forward a copy to each State Medical Board where you have ever held approval to perform/practice as a Respiratory Care Practitioner. You may want to contact each state to see if a fee is required.

**CLEARANCE FROM OTHER STATE BOARDS**

In applying for a license to practice as a Respiratory Care Practitioner in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or ever held a license/certificate. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding myself directly to:

SC Dept. of Labor, Licensing and Regulation  
Board of Medical Examiners  
110 Centerview Drive, Suite 202  
Post Office Box 11289  
Columbia, South Carolina 29211-1289  
(803) 896-4500  
Fax (803) 896-4515

**PLEASE TYPE OR PRINT**

Signature \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

**DO NOT DETACH**

*This section should be completed by an official of the state board and returned directly to the Board of Medical Examiners of South Carolina*

Full Name of Licensee: \_\_\_\_\_  
State of: \_\_\_\_\_ License/Certificate No.: \_\_\_\_\_  
Date Issued: \_\_\_\_\_ Date Expires: \_\_\_\_\_  
License/Certificate is current? \_\_\_\_\_ If no, why not? \_\_\_\_\_  
Has license been suspended, revoked or restricted? \_\_\_\_\_ If yes, why? \_\_\_\_\_  
Has licensee ever been required to appear before your Board? \_\_\_\_\_ If yes, why? \_\_\_\_\_  
Derogatory information, comments if any \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Board Seal)

Signature: \_\_\_\_\_  
Title: \_\_\_\_\_  
State Board of: \_\_\_\_\_  
Date: \_\_\_\_\_