



State of Maine

BOARD OF RESPIRATORY CARE PRACTITIONERS

Applicant information to assist in completing your application

Respiratory Care Therapist and Respiratory Care Technician

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Licensing and Registration
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8689 or Main Receptionist (207) 624-8603
TTY/Hearing Impaired 1-888-577-6690
FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing
Email: respcare.lic@maine.gov

**APPLICATION INSTRUCTION
RESPIRATORY CARE TECHNICIAN (CRT)
RESPIRATORY CARE THERAPIST (RRT)**

The following is a guideline to assist in your application process. It does not, however, replace the requirements outlined in the Board of Respiratory Care Practitioners Laws and Rules. Please review them carefully for more detailed and clarifying information.

Fax submissions of applications and supporting documentation will not be accepted

Two reference letters

Submit two reference letters (Board Rules Chapter 3(1)(C)(1))

License Verification

If you hold or have held a respiratory care license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Written confirmation of NBRC credentials.

You can reach the NBRC by Telephone: Toll-Free: 888 – 341 – 4811 or 913 – 895 – 4900 or via the internet at www.nbrc.org

Self query results for the HIPDB and the NPDB

In accordance with 10 MRS §8003, sub-§10, the Office of Licensing and Registration now requires all applicants to submit a NPDB/HIPDB* Self-Query Report as part of the initial application for licensure within each of the following allied health licensure programs effective 11/1/2007. The instructions to request a self-query report are available at NPDB/HIPDB's website: www.npdb-hipdb.hrsa.gov

CONTINUING EDUCATION

As a Respiratory Care Practitioner you will be required to satisfy the Continuing Education requirements identified in Chapter 4 of the Board's rules. Please be sure to review this chapter carefully.

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

The Board of Respiratory Care Practitioners requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

PROCESSING TIME:

- ✓ Please allow approximately three (3) weeks processing time from date of receipt.
- ✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Licensing and Registration's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 days for delivery.

VERIFICATION OF LICENSURE IN ANOTHER STATE OR JURISDICTION

If you hold or have held a respiratory care license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Please contact the state of licensure to request this an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked...
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken i.e. CRT, RRT
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF LICENSING AND REGISTRATION
INDIVIDUAL LICENSE APPLICATION**

APPLICANT INFORMATION (please print)

FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	- -
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ()	FAX # ()	E-MAIL	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime? (circle one)** **NO** **YES**
If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.
2. **Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one)** **NO** **YES**
If yes, enclose a detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE	DATE
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Board of Respiratory Care Practitioners

**Respiratory Therapist or Respiratory Care Technician
Required Fees: \$256.00**

(If applying after May 1st of an odd numbered year the Required Fees are: \$188.50)
(includes application, license and criminal records check fees)

LICENSE TYPE, check one:

- Respiratory Therapist *(TH1421)*
- Respiratory Care Technician *(TC1421)*

Office Use Only:

TH/TC 1446 - \$100.00
1447 - \$135.00/ \$67.50
2619 - \$ 21.00

Office Use Only:

Check # _____
Amount: _____
Cash # _____
Lic. # _____
Issue Date _____
Exp. Date _____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my			
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	the following amount: \$ _____	
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>

SIGNATURE	DATE
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SECTION 1: EDUCATION

Please check one:		
<input type="checkbox"/> NBRC Credentialed <input type="checkbox"/> Graduate of an AMA accredited respiratory care educational program		
College of Respiratory Care		Date of Graduation
Contact Address: Street or P.O. Box		
City	State	Zip Code
Note: If you are applying for licensure based on 32 MRS § 9708 (3)(A)(2) an Official transcript demonstrating your degree must be submitted with your application		

SECTION 2: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A RESPIRATORY CARE PRACTITIONERS LICENSE (TEMPORARY OR TRAINEE)

1. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
5. State, Territory, Country	License Number/Type	Date Issued	Expiration Date

For each of the above, you must submit with this application an official Verification of Licensure from the licensing jurisdiction. **IMPORTANT:** Applications submitted without all of the Verification of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

INITIALS OF APPLICANT

SECTION 3: Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

<p>Have you ever had a hospital or similar health care institution privileges ever been denied or which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <p>1. <input type="checkbox"/> Medicare <u>OR</u> <input type="checkbox"/> Medicaid Program (State) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

SECTION 4: NOTICES

Public Information

This application is a public record for purposes of Maine’s Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State’s website.

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

INITIALS OF APPLICANT

SECTION 4 (CONTINUED): NOTICES

Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Healthcare Integrity and Protection Data Bank (“HIPDB”) Self-Query Reports

In accordance with 10 MRS §8003(10), all applicants must submit a HIPDB Self-Query Report as part of the initial application for licensure. The instructions to request a self-query report are available at HIPDB’s website: www.npdb-hipdb.hrsa.gov The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information: **NPDB-HIPDB Customer Service Center**
Tel: (800)767-6732 - TDD: (703)802-9395

SECTION 5: APPLICANT’S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Respiratory Care Practitioners will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BOARD OF RESPIRATORY CARE PRACTITIONERS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
TEL:# (207) 624-8689 FAX # (207) 624-8637

PROFESSIONAL REFERENCE FORM
Please Complete This Form and Return Directly to Applicant

Name of Applicant:		
Contact Address of Applicant:		
City:	State:	Zip Code:
Email Address:	Telephone:	
In what professional capacity do you know the applicant?		
How long have you known the applicant?		
Are you related to the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how? _____		
Please give a brief statement of your knowledge of the applicant's ethical practice of respiratory care: _____ _____ _____ _____ _____		
Printed name: _____ Title: _____		
Signed: _____ Date: _____		
Contact Address:		
City:	State:	Zip Code:
Email Address:	Telephone:	