Respiratory Care Practitioner License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Respiratory Care Practitioner Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name, first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide your month, day, and year of birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification or Registration:**
List all jurisdictions, including Washington State, in which you hold or have held a license, certification, or registration. Verification is required on the form provided.

☐ **4. Examination Data:**
Official verification of the NBRC entry level examination in the form of scores or certificate must be sent directly from NBRC to the Department of Health.

☐ **5. Education:**
List in date order all high school and college education. Please request official transcripts to be sent directly from your college or university to the Department of Health. If you need more space, attach a sheet of paper.

☐ **6. Experience:**
List in date order all of your experience. If you need more space, attach a sheet of paper.

☐ **7. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in WAC 246-12-270.

☐ **8. Applicant's Attestation:**
You must sign and date this for us to process the application. Read this carefully.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at http://www.doh.wa.gov/hsqa/professions/military/ and include supporting documentation with your application.

Washington State Department of
Health

License Requirements

Thank you for applying to become a respiratory care practitioner in Washington State. To expedite the process, please include the following in your application.

☐ **Education:**
An applicant must be a graduate of a two-year respiratory therapy educational program. Programs must be Accredited by the Committee On Accreditation for Respiratory Care or by the American Medical Association's Committee on Allied Health Education and Accreditation, or its successor, the Commission on Accreditation of Allied Health Education Program.

☐ **Official Transcripts:** Your transcripts must indicate the degree and date conferred. The transcripts must come directly from your college or university to the Department of Health.

☐ **National Examination Scores:**
If you have taken and passed the National Board for Respiratory Care (NBRC) entry level examination, you meet the minimum examination requirements. The NBRC must send verification of your passing score directly to us. RCW 18.89.110, WAC 246-928-540.

☐ If you completed a one-year respiratory therapy education program you may qualify for license. You must meet the educational criteria as established by NBRC to sit for the NBRC's advanced practitioner exams. If you have been issued the registered respiratory therapist credential by the NBRC, you may be considered to have met the educational criteria. The NBRC must send verification of your passing score directly to us. RCW 18.89.110, WAC 246-928-540.

☐ **Temporary Practice Permit:**
(New graduates) If you are a recent graduate applying for temporary practice permit and your transcripts are not available, you may be issued a temporary practice permit upon submission of a letter from your program director verifying successful program completion and date of graduation. A full license will not be issued until we receive an official transcript. RCW 18.89.090, WAC 246-928-530.

- A temporary practice permit is available only to graduates who are awaiting the NBRC exam and have graduated from an approved program. RCW 18.89.090, WAC 246-928-530.
- You must sit and pass the examination within ninety days of graduation. RCW 18.89.090, WAC 246-928-530.
- An applicant who receives notification that s/he passed the examination may continue to practice under the supervision of a licensed respiratory care practitioner until the department has issued a license to the applicant.
- An applicant who receives notification of failure to pass the examination must cease practice immediately. The applicant can begin practicing again only after passing the examination and becoming licensed as a respiratory care practitioner by the department.

☐ **Letter from your school:**
If you are an exam applicant and your transcripts are not yet available, you can take the exam if you submit the required documents and a letter from your program director verifying successful program completion and date of graduation. We will not issue a full license until we receive an official transcript.

☐ **Temporary Practice Permit:**
(Out-of-State Licensees) If you hold or have held a license, certification, or registration in another state or jurisdiction, you may qualify for license in Washington State. The department will issue a one-time-only temporary practice permit unless it determines a basis for denial of the license or issuance of a conditional license. The temporary permit will expire when a license is issued, or within three months, whichever occurs first. The permit shall not be extended beyond the expiration date. Issuance of a temporary practice permit does not ensure that the department will grant a full license. Temporary permit holders are subject to the same education and examination requirements as a license holder. **RCW 18.89.090**, **WAC 246-928-520**, **WAC 246-928-550**.

Applicants must submit the following documentation to be considered for a temporary practice permit:

- Verification sent directly from all states or jurisdictions where the applicant is or was licensed. The verification is attesting that the applicant's license was or is in good standing and is not subject to charges or disciplinary action for unprofessional conduct or impairment.
- Verification of completion of the required education and examination. **RCW 18.89.090**, **WAC 246-928-520**.
- A 90-day temporary practice permit is available for out-of-state licenses. The permit allows you to work as a respiratory care practitioner until you receive your 7 hours of AIDS education prevention and training. **RCW 18.89.090**, **WAC 246-928-560**.

☐ **Continuing Education:**
Thirty credit hours of continuing respiratory care education is due every two years. A minimum of 10 hours must be approved by the American Association for Respiratory Care. **RCW 18.89.140**, **WAC 246-928-442**.

Washington State Department of Health

Revenue: 0252170000

Background Check Stamp Here

Date Stamp Here

Respiratory Care Practitioner License Application

Applying for:
- ☐ Full License
- ☐ Temporary Practice Permit (new graduate)
- ☐ Temporary Practice Permit (persons credentialed out of state)

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions) ☐ Male ☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City	State	Zip	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

Credential #____________________ Issue Date ____________________

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:

a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐

b. Diverted controlled substances or legend drugs? ☐ ☐

c. Violated any drug law? ☐ ☐

d. Prescribed controlled substances for yourself? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Other License, Certification, or Registration

List all jurisdictions, including Washington State, in which you hold or have held a license, certification, or registration. Verification is required on the form provided.

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently in Force	
		Type	Number	Year Issued		No	Yes

4. Examination Data

Have you taken and passed the NBRC entry level examination? ☐ Yes ☐ No

State Taken _______________ Year __________

Official verification in the form of scores or certificate must be sent directly from NBRC to the Department of Health.

5. Education

List in date order all high school and college education. Please request official transcripts to be sent directly from your college or university to the Department of Health. If you need more space, attach a sheet of paper.

School	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Degree and Major

6. Experience

List in date order all of your experience. If you need more space, attach a sheet of paper.

Type of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

7. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.
I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand that if I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

8. Applicant's Attestation

I, ____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated ___________________________________ at ____
(mm/dd/yyyy) (city, state)

By: ____
(signature of applicant)

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Respiratory Care Practitioner Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

PART 1: Note to Applicant

Complete Part 1. Submit form(s) to all state Respiratory Care Commissions/Boards/Committees where you have ever been licensed, certified or registered.

Name ____ .

I was licensed/certified/registered by the ____________________ Commission/Board/Committee of
State

Respiratory Care under the name ______________________________________ .

My original license/certification/registration number is ______________________ .

My Address is ____ .

Signature of applicant ____ .

PART 2:

To be completed by the ***state*** Respiratory Care Commission/Board/Committee and returned to the Washington State Department of Health at the address provided above.

License/Certification/Registration issued on __________ License Number ____________________

Applicant licensed by: Exam _______________ Endorsement ____________ Waiver ______________

Status of License/Certification/Registration: ☐ Current ☐ Not Current If not, explain ______________

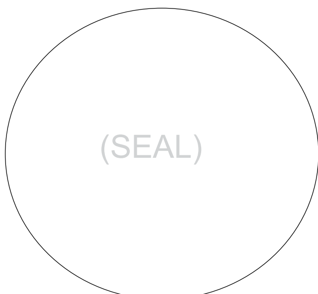
____

____

Has license/certification/registration ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, placed on probationary status, or under investigation.) ☐ Yes ☐ No If yes, explain __________

____

____



Signature ______________________________________

Name/Title ______________________________________

State ______________________________________

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.. RCW 18.130

Administrative Procedure Act .... RCW 34.05

Administrative procedures and requirements .... WAC 246-12

Respiratory Care Practitioner RCW.. RCW 18.89

Respiratory Care Practitioner WAC..WAC 246-928

On-Line

AIDS Training Resources ....Reference Page

Respiratory Care Practitioner Program ....Web Page