# Respiratory Care Practitioner License Application Packet

## Contents:



## Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

## In order to process your request:

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

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Respiratory Care Practitioner
Credentialing Section
P.O. Box 47877
Olympia, WA 98504-7877

**Contact us:**

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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# 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 printed clearly in ink. It is your responsibility to submit the required forms.

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

☐ **Check if either apply:**
Request for Military Training and Experience Evaluation
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
**Social Security Number:** You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.
**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**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.

**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.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification or Registration:**
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Credential Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **4. Examination Data or NBRC National Certification:**
Successful completion of one of the following:

A. Official verification from the NBRC of both the Therapist Multiple Choice Examination and the Clinical Simulation Examination must be sent directly from NBRC to the Department of Health.

B. Official verification of a Registered Respiratory Therapist national certification 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. Applicant's Attestation:**
You must sign and date this for us to process the application.

## For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

## For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

  **Please note:**
  - A copy of your DD214 can be downloaded from the **EBenefits website**.
  - You can request a replacement copy of your NGB-22 on the **National Archives website**.
- Official Joint Service Transcript (JST) or Community College of the Air Force(CCAF) Transcripts.

  **Please note:**
  - JST can be sent electronically by visiting the **JST website** and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the **CCAF website** for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the **DoDTAP website**.
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the **Military Resources website**.

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# 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 at least 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:**
If you have taken and passed both the Therapist Multiple-Choice Examination and Clinical Simulation Examination by the National Board for Respiratory Care (NBRC), you meet the minimum examination requirements. The NBRC must send official verification of your passing score directly to the Department of Health.
An active Registered Respiratory Therapist credential with NBRC is considered proof of meeting the minimum examination requirements. Official verification must be sent to the Department of Health. RCW 18.89.110, WAC 246-928-540.

☐ **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 246-928-540, WAC 246-928-560, WAC 246-928-570.

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. RCW 18.89.090, WAC 246-928-560, WAC 246-928-570.

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Washington State Department of HEALTH

Date Stamp Here

**Revenue: 0252170000**

# Respiratory Care Practitioner License Application

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

Select the requirements you have completed: ☐ Therapist Multiple-Choice Examination
☐ Clinical Simulation Examination ☐ Active Registered Respiratory Therapist NBRC national certification
☐ Graduate of at least a two-year respiratory therapy educational program

**Select if either apply:** ☐ Request for Military Training and Experience Evaluation
☐ Spouse or Registered Domestic Partner of Military Personnel

## 1. Demographic Information

| **Social Security Number (SSN)** (If you do not have a SSN, see instructions) | **National Provider Identifier Number (NPI)** (Enter 10 digit number) | ☐ Male ☐ Female ☐ Prefer not to answer ☐ X |
|---|---|---|

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

| City | State | Zip Code | 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 Code | 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):

## 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.**

   **If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.**

   **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

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? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

## 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 |
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## 4. Examination Data

Have you taken and passed the NBRC Therapist Multiple-Choice Examination and Clinical Simulation Examination for the Registered Respiratory Therapist?

☐ Yes Multiple Choice Date: _____ Simulation Date: _____ ☐ No

Are you currently active as a Registered Respiratory Therapist through NBRC?

☐ Yes Date: _____ ☐ No

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 |
|---|---|---|---|
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## 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) |
|---|---|---|
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## 7. 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 have read all laws and rules related to my profession.

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 _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

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# RCW/WAC and Online Website 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 Laws, RCW 18.89

Respiratory Care Practitioner Rules, WAC 246-928

## Online

Respiratory Care Practitioner Program, Web Page