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**Rules of**  
**Department of Economic Development**  
**Division 255—Missouri Board for Respiratory Care**  
**Chapter 2—Licensure Requirements**

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**Title 4—DEPARTMENT OF  
ECONOMIC DEVELOPMENT****Division 255—Missouri Board for  
Respiratory Care****Chapter 2—Licensure Requirements****4 CSR 255-2.010 Application for Licensure**

*PURPOSE:* This rule outlines the procedure for application for licensure as a respiratory care practitioner.

(1) Application for licensure shall be submitted on the forms provided by the board and may be obtained by writing the board at 3605 Missouri Boulevard, P.O. Box 1335, Jefferson City, MO 65102 or by calling (573) 522-5864. The TDD number is (800) 735-2966.

(2) An application is not considered officially filed with the board until it has been determined by the board or division staff to be complete and the application is submitted on the form provided by the board, typewritten or printed in black ink, signed, notarized and accompanied by application fee pursuant to rules promulgated by the board, a full set of fingerprints with the appropriate fee as defined by the rules promulgated by the board and any other applicable forms. All information should be received by the board within ninety (90) days of the date of the application.

(3) The applicant shall request that the National Board for Respiratory Care (NBRC) or its successor organization(s) send a letter directly to the board verifying the applicant's credentials. The applicant is responsible for the payment of any fees required by the NBRC for the issuance of a verification letter.

(4) The applicant shall request that each state, United States Territory, province, or country regulatory entity in which a license, certificate, registration or permit as a respiratory care practitioner, respiratory therapist, respiratory therapy technician or similar title is held or has ever been held to submit verification of licensure, certification, registration or permit directly to the board. The verification shall include the license, registration, certification or permit issued, the number, status, issue and expiration dates, information regarding any disciplinary action, method of licensure, registration or certification, the name and title of person verifying information with date and board seal.

(5) The applicant shall submit a full set of fingerprints with the appropriate fee pursuant to rules promulgated by the board unless the applicant previously submitted fingerprints

for a temporary or educational permit issued by the board.

(A) For the purpose of this rule, fingerprints shall be obtained from a law enforcement agency or may be obtained from the Missouri Board for Respiratory Care. Applicants desiring fingerprinting by the board shall contact the board at least twenty-four (24) hours in advance to schedule an appointment during normal business hours.

(6) Following review by the board, the applicant shall be informed in writing of the decision regarding the application for licensure. Applicants that are approved for licensure will receive one (1) license certificate. Duplicate licenses may be provided upon payment of the appropriate fee pursuant to rules promulgated by the board.

*AUTHORITY:* sections 334.800, 334.840.2, 334.850(2), (4), (6), and 334.870, RSMo Supp. 1997. \* Emergency rule filed June 25, 1998, effective July 6, 1998, expired Feb. 25, 1999. Original rule filed June 25, 1998, effective Jan. 30, 1999.

\*Original authority: 334.800, RSMo 1996; 334.840, RSMo 1996; 334.850, RSMo 1996; and 334.870, RSMo 1996.



APPLICATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER

INSTRUCTIONS

- Please read this form before completing.
This form must be typed or printed legibly in black ink.
Provide complete information (Incomplete information will delay review of your application).
Enclose the \$65.00 application fee made payable to the Missouri Board for Respiratory Care. Payment must be made in the form of a check or money order.
Request that the National Board for Respiratory Care (NBRC) send verification of your credentials directly to the Missouri Board for Respiratory Care (Copies of certificates or wallet cards issued by the NBRC are not acceptable). A verification request form is provided with this application.
Obtain fingerprints upon the card that is enclosed with this application. Fingerprints must be obtained from a law enforcement agency or at the Board's Office.
If you are or have ever been licensed, certified, registered or been granted a permit as a respiratory care practitioner by another state, territory of the United States, or province or country, request that verification of your license, registration, certification or permit be submitted by each state, territory, province or country upon the enclosed verification of licensure form. This form must be received directly from the other state(s), territory, country or province in which a license, certification, registration or permit was held.
Affix a recent photograph of yourself in the space provided to the right of this section.

RETURN NOTARIZED APPLICATION FORM, FEE AND FINGERPRINTS TO:

MISSOURI BOARD FOR RESPIRATORY CARE
3605 MISSOURI BOULEVARD
P.O. BOX 1335
JEFFERSON CITY MO 65102-1335
TELEPHONE: (573) 522-5864
TDD: (800) 735-2966

AFFIX PHOTOGRAPH

This application is being submitted on the basis of:

- New Applicant
Reciprocity
Reinstatement

APPLICANT DATA

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)

Form fields for SOCIAL SECURITY NUMBER, DATE OF BIRTH, RESIDENCE TELEPHONE NUMBER, RACE, GENDER, RESIDENCE STREET ADDRESS, CITY, STATE, ZIP, CURRENT PLACE OF EMPLOYMENT, EMPLOYMENT TELEPHONE NUMBER, EMPLOYMENT ADDRESS, CITY, STATE, ZIP.

WERE YOU REGISTERED WITH THE STATE OF MISSOURI, OFFICE OF HEALTH CARE PROVIDERS AS A RESPIRATORY CARE PRACTITIONER?

- YES
NO

EDUCATION (Also include any military medical training) (If additional space is needed please attach sheets as necessary.)

Table with columns: COLLEGE, UNIVERSITY OR PROFESSIONAL SCHOOL; CITY/STATE; DATES ATTENDED (FROM MON, YR. TO MON, YR.); DEGREE OR CERTIFICATE AWARDED/ DATE; MAJOR COURSE OF STUDY.

**NATIONAL CREDENTIALS**

I HOLD THE FOLLOWING CREDENTIAL(S) ISSUED BY THE NATIONAL BOARD FOR RESPIRATORY CARE (NBRC)

- CERTIFIED RESPIRATORY THERAPY TECHNICIAN, (CRTT), ISSUE DATE: \_\_\_\_\_
- REGISTERED RESPIRATORY THERAPIST, (RRT), REGISTRY NUMBER: \_\_\_\_\_

HAVE YOUR CREDENTIALS EVER BEEN DISCIPLINED, SANCTIONED, SUSPENDED OR REVOKED? IF YES, EXPLAIN.

YES  NO

**PROFESSIONAL EXPERIENCE - LIST ALL EMPLOYERS IN THE PAST FIVE YEARS**

**BEGIN WITH THE MOST RECENT EMPLOYMENT, USING ADDITIONAL SHEETS IF NECESSARY**

A. NAME AND ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM		TO		IMMEDIATE SUPERVISOR'S NAME AND ADDRESS
MON.	YR.	MON.	YR.	

TITLE OF APPLICANT'S POSITION				LENGTH OF EXPERIENCE IN THIS POSITION (YEARS, MONTHS)

B. NAME AND ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM		TO		IMMEDIATE SUPERVISOR'S NAME AND ADDRESS
MON.	YR.	MON.	YR.	

TITLE OF APPLICANT'S POSITION				LENGTH OF EXPERIENCE IN THIS POSITION (YEARS, MONTHS)

C. NAME AND ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM		TO		IMMEDIATE SUPERVISOR'S NAME AND ADDRESS
MON.	YR.	MON.	YR.	

TITLE OF APPLICANT'S POSITION				LENGTH OF EXPERIENCE IN THIS POSITION (YEARS, MONTHS)



LICENSURE, CERTIFICATION OR REGISTRATION

The applicant must answer the following questions. If any of the questions are answered yes, the applicant must provide an explanation.

YES NO

- 1. Have you ever been issued a professional license, certification, registration, or permit by any State, United States Territory, province or country? If yes, please list the state, territory, province or country, type of license with license number, status of license, and your name as it appears on the license.
2. Have you ever been denied a professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement.
3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? If yes, explain fully in a separate notarized statement.
4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold? If yes, explain fully in a separate notarized statement.
5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement.
6. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed, (excluding traffic violations)? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.
7. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.
8. Do you currently, or did you within the past five years, use any prescription drug, controlled substance, illegal chemical substance, or alcohol, to the point where your ability to competently practice as a respiratory care practitioner would be affected? If yes, explain fully in a separate notarized statement.
9. Are you now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program? If yes, explain fully in a separate notarized statement and attach verification of chemical or alcohol dependency treatment.
10. Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception or malpractice related to your practice as a respiratory care practitioner? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.
11. Do you have a medical condition that in any way impairs or limits your ability to perform with reasonable care and safety the essential functions of a respiratory care practitioner with or without reasonable accommodations? If yes, explain fully in a separate notarized statement.

**SWORN AFFIDAVIT**

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a license to practice respiratory care in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit in consideration this application as required by the Missouri law governing the practice of respiratory care and subject to the rules and regulations of the Missouri Board for Respiratory Care. I subscribe and agree to abide by all applicable laws and rules regarding the practice of respiratory care. I hereby certify that I have familiarized myself with sections 334.800-334.930 RSMo, known as the Respiratory Care Practice Act and applicable rules promulgated by the Missouri Board for Respiratory Care.

Enclosed is the application fee which is not refundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY</b>		SIGNATURE OF APPLICANT ▶	
NOTARY PUBLIC EMBOSSEER OR BLACK INK RUBBER STAMP SEAL	STATE OF	COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF		19
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		



**MISSOURI**  
DEPARTMENT OF ECONOMIC DEVELOPMENT

BOARD FOR RESPIRATORY CARE

**REQUEST FOR VERIFICATION OF CREDENTIALS**

**INSTRUCTIONS**

**TO APPLICANT:**

Please complete Section I below. Current registry members must forward a \$3 credential verification fee. Non-current members must forward a \$15 credential verification fee to:

National Board for Respiratory Care, Inc.  
8310 Nieman Road  
Lenexa, Kansas 66214  
Telephone: (913) 599-4200

**TO NBRC:**

Please complete Section II below and return completed form to:

Missouri Board for Respiratory Care  
P O Box 1335  
Jefferson City, MO 65102-1335  
Telephone: (573) 522-5864

**SECTION I**

I am applying for state licensure in Missouri, and I am requesting the NBRC verify my respiratory therapy credentials directly to the Missouri Board for Respiratory Care.

I HOLD THE FOLLOWING NBRC CREDENTIALS:  RRT  CRTT

DATE CREDENTIALS EARNED

PRINT NAME UNDER WHICH YOU WERE CREDENTIALLED (LAST, FIRST, MIDDLE INITIAL)

APPLICANT FULL NAME (PLEASE PRINT) (LAST, FIRST, MIDDLE INITIAL)

SOCIAL SECURITY NUMBER

SIGNATURE

DATE

**SECTION II (For NBRC use only)**

The above named person has achieved the minimum passing score required for successful completion of an examination and earned the following NBRC credentials:

CREDENTIALS	DATE CREDENTIALLED
<input type="checkbox"/> CRTT	
<input type="checkbox"/> RRT (NUMBER _____)	
SIGNATURE	DATE

NOT VALID UNLESS STAMPED BY NBRC (IN SPACE BELOW)



**MISSOURI**  
DEPARTMENT OF ECONOMIC DEVELOPMENT

MISSOURI BOARD FOR RESPIRATORY CARE  
P.O. BOX 1335  
3605 MISSOURI BOULEVARD  
JEFFERSON CITY, MO 65102-1335  
TELEPHONE: (573) 522-5864  
TDD (800) 735-2966

**VERIFICATION OF LICENSURE**

**INSTRUCTIONS**

Complete Section I and mail this form to each state, United States Territory, province or country that you have or ever have had a license, certification, registration, temporary license or a temporary permit to practice respiratory care. This verification must be returned to the Missouri Board for Respiratory Care within ninety (90) days of your application. Some states do require a fee for providing verification information. To expedite your application, you may wish to contact the applicable state(s), U.S. territory, province or country. This form may be photocopied as necessary.

**SECTION I - TO BE COMPLETED BY APPLICANT**

NAME (FIRST, MIDDLE, LAST, SUFFIX)

NAME AS IT APPEARS ON LICENSE/CERTIFICATION/REGISTRATION/PERMIT

TYPE OF LICENSE/CERTIFICATION/REGISTRATION/PERMIT HELD

NUMBER ISSUED

SOCIAL SECURITY NUMBER

DATE OF BIRTH

The Missouri Board for Respiratory Care requests that I submit evidence of the status of my license, certification, registration, permit in your state. You are hereby authorized to release any information in your possession pertaining to me, favorable or otherwise, directly to the Missouri Board for Respiratory Care, P.O. Box 1335, Jefferson City, MO 65102.

APPLICANT SIGNATURE

DATE

**SECTION II - TO BE COMPLETED BY ADMINISTRATIVE OFFICE OF OTHER REGULATORY AGENCY**

TYPE OF REGULATION

LICENSE       CERTIFICATION       REGISTRATION       PERMIT HOLDER

LICENSE NUMBER

ISSUE DATE

EXPIRATION DATE

LICENSE WAS ISSUED ON THE BASIS OF

NBRC CREDENTIALS       STATE EXAMINATION       EDUCATION       GRANDFATHER CLAUSE  
 OTHER \_\_\_\_\_

HAS THE APPLICANT'S LICENSE EVER LAPSED?

YES     NO    IF YES, EXPLAIN

HAS THE APPLICANT EVER BEEN RESTRICTED OR DISCIPLINED IN ANY WAY?

YES     NO    IF YES, EXPLAIN

DOES THE APPLICANT HAVE ANY PENDING COMPLAINTS?

YES     NO    IF YES, EXPLAIN

SIGNATURE

DATE

NAME PRINTED

TITLE

PLEASE AFFIX  
BOARD SEAL

MO 419-2276 (12-97)

**4 CSR 255-2.020 Application for Temporary Permit**

*PURPOSE: This rule outlines the procedure for application for a temporary permit.*

(1) Application for a temporary permit shall be submitted on the forms provided by the board and may be obtained by writing the board at 3605 Missouri Boulevard, P.O. Box 1335, Jefferson City, MO 65102 or by calling (573) 522-5864. The TDD number is (800) 735-2966.

(2) An application for a temporary permit is not considered officially filed with the board until it has been determined by the board or division staff to be complete and the application is submitted on the form provided by the board, typewritten or printed in black ink, signed, notarized and accompanied by the application fee for temporary permit pursuant to rules promulgated by the board, verification of respiratory care work experience, and a full set of fingerprints with the appropriate fee pursuant to rules promulgated by the board. All information should be received by the board within ninety (90) days of application.

(3) The applicant shall request and obtain on forms provided by the board verified evidence of—

(A) Performance of the duties of a respiratory care practitioner for the previous twelve (12) months as defined in section 334.800, RSMo and evidence of being a veteran of the United States military services with at least six (6) months respiratory care experience as a member of the military; or

(B) Performance of the duties of a respiratory care practitioner for the previous twelve (12) months as defined in section 334.800, RSMo and evidence of six (6) months respiratory care experience in a United States territory or foreign country; or

(C) Special on-the-job training and the performance of the duties of a respiratory care practitioner on August 28, 1996.

(4) The applicant shall request that each state, United States territory, province, or country regulatory entity in which a license, certificate, registration or permit as a respiratory care practitioner, respiratory therapist, respiratory therapy technician or similar title is held or has ever been held to submit verification of licensure, certification, registration or permit directly to the board. The verification shall include the license, registration, certification or permit issued, the number, status, issue and expiration dates, information regarding any disciplinary action, method of

licensure, registration or certification, the name and title of person verifying information with date and board seal.

(5) The applicant shall submit a full set of fingerprints on the form provided by the board with the appropriate fee pursuant to rules promulgated by the board, unless the applicant previously submitted fingerprints for an educational permit issued by the board.

(A) For the purpose of this rule, fingerprints shall be obtained from a law enforcement agency or may be obtained from the Missouri Board for Respiratory Care. Applicants desiring fingerprinting by the board shall contact the board at least twenty-four (24) hours in advance to schedule an appointment during normal business hours.

(6) The applicant shall submit registration of supervision on forms provided by the board.

(7) Following review by the board, the applicant shall be informed in writing of the decision regarding the application for permit. Applicants that are approved will receive one (1) permit. Duplicate permits may be provided upon payment of the appropriate fee pursuant to rules promulgated by the board.

(8) The permit holder must notify the board of any change in supervision within fifteen (15) days of the change.

*AUTHORITY: sections 334.800, 334.840.2, 334.850 and 334.890.2-4, RSMo Supp. 1997.\* Emergency rule filed June 25, 1998, effective July 6, 1998, expired Feb. 25, 1999. Original rule filed June 25, 1998, effective Jan. 30, 1999.*

*\*Original authority: 334.800, RSMo 1996; 334.840, RSMo 1996; 334.850, RSMo 1996; and 334.890, RSMo 1996.*



# MISSOURI

DEPARTMENT OF ECONOMIC DEVELOPMENT

## APPLICATION FOR PERMIT

**INSTRUCTIONS**

- Please read this form before completing.
- This form must be typed or printed legibly in black ink.
- Provide complete information (Incomplete information will delay review of your application).
- Enclose the application fee made payable to the Missouri Board for Respiratory Care. Payment must be made in the form of a check or money order.
- Obtain fingerprints upon the card that is enclosed with this application. Fingerprints must be obtained from a law enforcement agency or at the Board's Office.
- A permit holder may only perform and provide services of a respiratory care practitioner under the direct clinical supervision of a licensed respiratory care practitioner. Supervisors must be approved by the Board. Have your supervisor complete the enclosed supervision registration form and submit the form with this application.
- If you are or have ever been licensed, certified, registered or been granted a permit as a respiratory care practitioner by another state, territory of the United States, province or country request that verification of your license, registration, certification, or permit be completed by each state, territory, province or country upon the enclosed verification of licensure form. This form must be received directly from the other state(s), territory, province or country in which a license, certification, registration or permit was held.
- Affix a recent photograph of yourself in the space provided to the right of this section.

RETURN NOTARIZED APPLICATION FORM, SUPERVISION REGISTRATION, FEE AND FINGERPRINTS TO:

MISSOURI BOARD FOR RESPIRATORY CARE  
 3605 MISSOURI BOULEVARD  
 P.O. BOX 1335  
 JEFFERSON CITY MO 65102-1335  
 TELEPHONE: (573) 522-5864  
 TDD: (800) 735-2966

AFFIX PHOTOGRAPH

**TYPE OF APPLICATION:**

- Temporary Permit (this permit may be issued only once to an individual and is valid for eighteen (18) months)  
 Application Fee: \$50

The Missouri Board for Respiratory Care must receive verification of your work experience directly from a supervisor, medical director, department director or human resource department on the enclosed verification of work experience form.

I am submitting this application based upon the fact that (check all that apply):

- 1. I have six (6) months of verifiable military experience in the practice of respiratory care; or
  - 2. I have been performing the duties of a respiratory care practitioner as defined in Section 334.800, RSMo, of the Respiratory Care Practice Act for the previous twelve (12) months in a U.S. territory or foreign country; or
  - 3. I have had special on-the-job training in the practice of respiratory care on August 28, 1996 and am currently performing the duties of a respiratory care practitioner as defined in Section 334.800, RSMo, of the Respiratory Care Practice Act.
- Temporary Educational Permit (this permit may be issued to an individual that is currently enrolled in an accredited respiratory care program and is valid up to twelve (12) months after completion of the educational program)  
 Application Fee: \$25

You must have the enclosed verification of education form completed and mailed directly to the Missouri Board for Respiratory Care.

**APPLICANT DATA**

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)			
SOCIAL SECURITY NUMBER*	DATE OF BIRTH	RESIDENCE TELEPHONE NUMBER	
RACE (THIS INFORMATION IS VOLUNTARY)		GENDER (THIS INFORMATION IS VOLUNTARY)	
RESIDENCE STREET ADDRESS (IF P.O. BOX, PLEASE ALSO PROVIDE A STREET ADDRESS)	CITY	STATE	ZIP
CURRENT PLACE OF EMPLOYMENT	EMPLOYMENT TELEPHONE NUMBER		
EMPLOYMENT ADDRESS	CITY	STATE	ZIP

**EDUCATION (Also include any military medical training)**

COLLEGE, UNIVERSITY OR PROFESSIONAL SCHOOL	CITY/STATE	DATES ATTENDED				DEGREE OR CERTIFICATE AWARDED/ DATE	MAJOR COURSE OF STUDY
		FROM		TO			
		MON.	YR.	MON.	YR.		

**PROFESSIONAL EXPERIENCE**

**BEGIN WITH THE MOST RECENT EMPLOYMENT, USING ADDITIONAL SHEETS IF NECESSARY**

A. NAME AND ADDRESS OF EMPLOYER

---

NATURE OF BUSINESS

---

FROM		TO		IMMEDIATE SUPERVISOR'S NAME AND ADDRESS
MON.	YR.	MON.	YR.	
				TITLE OF APPLICANT'S POSITION
				MONTHS EXPERIENCE

RESPIRATORY DUTIES PERFORMED

---

B. NAME AND ADDRESS OF EMPLOYER

---

NATURE OF BUSINESS

---

FROM		TO		IMMEDIATE SUPERVISOR'S NAME AND ADDRESS
MON.	YR.	MON.	YR.	
				TITLE OF APPLICANT'S POSITION
				MONTHS EXPERIENCE

RESPIRATORY DUTIES PERFORMED

---

C. NAME AND ADDRESS OF EMPLOYER						
NATURE OF BUSINESS						
FROM		TO		IMMEDIATE SUPERVISOR'S NAME AND ADDRESS		
MON.	YR.	MON.	YR.			
				TITLE OF APPLICANT'S POSITION	MONTHS EXPERIENCE	
RESPIRATORY DUTIES PERFORMED						
<b>LICENSURE, CERTIFICATION OR REGISTRATION</b>						
					<b>YES</b>	<b>NO</b>
<b>The applicant must answer the following questions. If any of the questions are answered yes, the applicant must provide an explanation.</b>						
1. Have you ever been issued a professional license, certification, registration, or permit by any State, United States Territory, province or country? If yes, please list the state, territory, province or country, type of license with license number, status of license, and your name as it appears on the license.					<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been denied a professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement.					<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? If yes, explain fully in a separate notarized statement.					<input type="checkbox"/>	<input type="checkbox"/>
4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold? If yes, explain fully in a separate notarized statement.					<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement.					<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed, (excluding traffic violations)? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.					<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.					<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
8. Do you currently, or did you within the past five years, use any prescription drug, controlled substance, illegal chemical substance, or alcohol, to the point where your ability to competently practice as a respiratory care practitioner would be affected? If yes, explain fully in a separate notarized statement.	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program? If yes, explain fully in a separate notarized statement and attach verification of chemical or alcohol dependency treatment.	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception or malpractice related to your practice as a respiratory care practitioner? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a medical condition that in any way impairs or limits your ability to perform with reasonable care and safety the essential functions of a respiratory care practitioner with or without reasonable accommodations? If yes, explain fully in a separate notarized statement.	<input type="checkbox"/>	<input type="checkbox"/>

**SWORN AFFIDAVIT**

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a permit to practice respiratory care in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit in consideration this application as required by the Missouri law governing the practice of respiratory care and subject to the rules and regulations of the Missouri Board for Respiratory Care. I subscribe and agree to abide by all applicable laws and rules regarding the practice of respiratory care. I hereby certify that I have familiarized myself with sections 334.800-334.930 RSMo, known as the Respiratory Care Practice Act and applicable rules promulgated by the Missouri Board for Respiratory Care.

I understand that I must perform respiratory care services only under the direct clinical supervision of a licensed respiratory care practitioner as approved by the Missouri Board for Respiratory Care. If, for any reason the arrangements for my supervision should change, I will notify the Missouri Board for Respiratory Care immediately.

Enclosed is the application fee which is not refundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY</b>  <small>NOTARY PUBLIC EMBOSSEY OR BLACK INK RUBBER STAMP SEAL</small>	SIGNATURE OF APPLICANT		
	STATE OF	COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS		<b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>
	DAY OF	19	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
NOTARY PUBLIC NAME (TYPED OR PRINTED)			