STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 741-3807 OR 1-800-778-4123 ext. 741-3807
http://tennessee.gov/health/topic/rc-board

APPLICATION INSTRUCTIONS FOR LICENSURE AS REGISTERED RESPIRATORY THERAPIST (RRT) OR CERTIFIED RESPIRATORY THERAPIST (CRT OR CRTT)
LICENSURE APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail or by email. The supporting documentation requested in the letter must be received in the Board's Administrative Office within sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.**

		Done
1.	Complete all pages of this application and return to the above address.	_____
2.	Request that proof of NBRC Certification or official verification of passage of the entry-level or advanced level practitioner examination provided by NBRC be submitted directly to the Board office from NBRC.	_____
3.	If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a Certified Respiratory Therapist or in any other health care profession, you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).	_____
4.	If Arterial Blood Gas (ABG) endorsement is desired, the applicant must have their school send directly to the Board office, a final transcript which shows the applicant's training in blood gas analysis.	_____
5.	Request that certificate of completion, diploma, or final official transcript from the school where respiratory care education or training program was completed be submitted directly from the school to the Board's administrative office. The institution submitting the certificate of completion, diploma or final official transcript must be accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or its successor organization or other accrediting organization recognized by the Board at the time of completion of the education or training program.	_____
6.	Attach a recent passport-size photograph of yourself taken within the last 12 months.	_____
7.	Submit with the application, a check or money order in U.S. funds in the amount of $160.00, which includes an application fee of $70.00, license fee of $80.00 and a $10.00 state regulatory fee made payable to the State of Tennessee. (If applying for an upgrade as listed in #7, this fee is not applicable.)	_____
8.	If licensed in the state of Tennessee as a certified Respiratory Therapist (CRT or CRTT) and wish to upgrade to a Registered Respiratory Therapist (RRT), submit with the application a check or money order in U.S. funds in the amount of $30.00, which includes a $20.00 upgrade fee and a $10.00 state regulatory fee, made payable to the State of Tennessee.	_____
9.	Complete and submit the Practitioner Profile Questionnaire which is online and will be available for you to complete online once this application is submitted. You are required by law to update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. . For instructions, go to (http://tn.gov/assets/entities/health/attachments/PH-3585.pdf)	_____
10.	A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions	_____

11. All applicants must complete, sign and have notarized the Declaration of Citizenship form and attach the documents required by the Declaration of Citizenship. The Declaration is online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf and must be attached to this application before submission. _____

12. If you wish to receive an endorsement by the Tennessee Board of Respiratory Care to provide polysomnographic services pursuant to Tenn. Code Ann. § 63-31-107(a)(5), there is a separate application form to be completed and submitted to the Board's administrative office. This form must be signed and/or notarized prior to submission to the Board. The application is available online at http://tennessee.gov/assets/entities/health/attachments/PH-4110.pdf . _____

APPLICATION INSTRUCTIONS FOR TEMPORARY LICENSURE

Pursuant to T.C.A. § 63-27-116, the Board may issue a temporary license to applicants for licensure as a registered respiratory therapist or certified respiratory therapist who have successfully completed the required academic and clinical preparation in a respiratory care program accredited by the American Medical Association Committee on Allied Health Education and Accreditation (CAHEA) in collaboration with the Joint Review Committee for Respiratory Therapy Education (JRCRTE) or their successor organizations, and are scheduled to take the National Board Respiratory Care (NBRC) examination.

A temporary license can only be issued for a period not to exceed twelve (12) months. If notification of successful completion of the examination is not received in the Board office within one (1) year from the date of issuance, the application will be considered abandoned and closed. A temporary license will become invalid at the time a permanent license is issued.

Applicants for a temporary license should please follow all instructions listed above in submitting an application to the Board.

APPLICATION INSTRUCTIONS FOR LICENSURE BY RECIPROCITY

The Board may issue a license by endorsement to applicants for licensure as registered respiratory therapists or certified respiratory therapists who are currently licensed to practice respiratory care under the laws of another state, territory or country, whose qualifications are deemed by the Board to be equivalent to those required in Tennessee, and who have successfully completed the required academic and clinical preparation in a respiratory care program approved by the Commission on Accreditation of Allied Health Education Programs or its successor organization or other accrediting organization recognized by the Board.

Request that official verification of passage of the advanced level practitioner or entry-level examination be submitted directly to the Board office from NBRC. Endorsement applicants must submit proof of having completed twelve (12) hours of CE in the previous calendar year.

If Arterial Blood Gas (ABG) endorsement is desired, the applicant must submit verification to the Board that he/she holds a current CRT or RRT credential issued by NBRC or an individual can obtain ABG endorsement by submitting verification to the Board of a current "Special Analyst-Blood Gas" license issued by the Tennessee Medical Laboratory Board.

Graduates of educational programs not accredited by the American Medical Association Committee on Allied Health Education and Accreditation must submit certified official copy of grades and curriculum, translated into English and the results of an evaluation of the educational credentials, evaluated by either a professional credentialing agency or an institution of higher education, submitted directly to the board's administrative office from the evaluator on the evaluator's official letterhead with an original signature.

If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a Registered Respiratory Therapist or Certified Respiratory Therapist or in any other health care profession, you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).

Applicants for a license by reciprocity should please follow all instructions listed above in submitting an application to the Board.

APPLICATION INSTRUCTIONS FOR LICENSE UPGRADE

The Board may issue a license upgrade to certified respiratory therapists applying for licensure as a registered respiratory therapist who have successfully completed the required academic and clinical preparation in a respiratory care program approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) in collaboration with Commission on Accreditation for Respiratory Care (CoARC) or their successor organizations or other accrediting organization recognized by the Board.

Request that certificate of completion, diploma, or final official transcript from the school where respiratory care education or training program was completed be submitted directly from the school to the Board's administrative office. The institution submitting the certificate of completion, diploma or final official transcript must be accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization or other accrediting organization recognized by the Board at the time of completion of the education or training program.

Request that proof of NBRC Certification or official verification of passage of the advanced level practitioner examination provided by NBRC be submitted directly to the Board office from NBRC.

If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a Certified Respiratory Therapist or in any other health care profession, you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).

Applicants for a license by reciprocity should please follow all instructions listed above in submitting an application to the Board.

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs <u>at any time, you must</u> notify the Board office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

For Federal Express or Special Courier:
Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37228

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you <u>will</u> be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. **We will discuss application status with the applicant or applicant's spouse <u>only</u>**. Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.

5. If all necessary documentation has not been received when your application is received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office <u>sixty (60) days</u> from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

6. **Absent any complicating factors, <u>the average application processing time is six weeks</u>. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.**

7. It is recommended that you <u>do not</u> make arrangements to accept employment as a Respiratory Care Practitioner in Tennessee until you are granted a license, temporary permit or temporary license by the Board of Respiratory Care.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have either a Tennessee License or a Board issued authorization in your possession before you may lawfully practice as either a Registered or Certified Therapist.

ATTACH A
CURRENT PASSPORT
STYLE PHOTOGRAPH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243
BOARD OF RESPIRATORY CARE
(615) 741-3807 or Toll Free 1-800-778-4123 ext. 741-3807

RRT	3747 – 001	$ 70.00
	3747 – 001	$ 80.00
	3747 – 006	$ 10.00
		$ 160.00
CRT	3750 – 001	$ 70.00
	3750 – 001	$ 80.00
	3750 – 006	$ 10.00
		$ 160.00
Upgrade	3747 – 001	$ 20.00
	3747 – 006	$ 10.00
		$ 30.00

LICENSURE APPLICATION

Choose the appropriate certificate category and any endorsements for which you qualify within the category. See the Practice Act and the Rules and Regulations to determine the requirements for each category of practitioner.

LICENSURE ALTERNATIVES

A. _____Temporary License _____ Registered Therapist _____ Certified Therapist	C. _____ Upgrade from Certified Therapist to Registered Therapist
B. _____ Registered Therapist _____ By Examination _____ By Reciprocity	D. _____ Certified Therapist _____ By Examination _____ By Reciprocity
For Office Use Only	
_____ License Qualified	_____ Temporary Authorization
_____ ABG Endorsement Qualified	_____ Temporary License Qualified

PERSONAL INFORMATION

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number*: _____ U.S. Citizen: Yes ___ No___
All applicants must complete the Declaration of Citizenship form

Date of Birth: _____ Entitled to Live and Work in the U.S. Yes ___ No___

Mailing Address: _____

_____ Zip _____

Practice Address: _____

_____ Zip _____

E-mail address: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. __Yes __ No

Race: _____ Phone: Home: _____

Gender: Female _____ Male _____ Office: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No ____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No ____

Have you ever been known by any other names besides what is listed above? Yes ____ No ____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

_____

***You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.**

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for your attendance in college. Please include your post-graduate training. Use the back of this page if you need additional space. Request that transcripts be sent directly to the Board's Office from your school.

From: _____ _____ _____ _____
MM/DD/YY MM/DD/YY Educational Institution Location

From: _____ _____ _____ _____
MM/DD/YY MM/DD/YY Educational Institution Location

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	**Supervisor**	**Address: (City, and State)**	**Position:**	**Duties:**	**Dates From: Mo./Yr.**	**To: Mo./Yr.**

CERTIFICATION INFORMATION

	YES	NO
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	**PROFESSION**	**LICENSE NUMBER**	**CURRENT STATUS**

	YES	NO
1. Are you certified (CRT or CRTT) by the National Board for Respiratory Care?	____	____
2. Are you registered (RRT) by the National Board for Respiratory Care?	____	____
3. Have you ever previously applied for a Certified Therapist license in Tennessee?	____	____
4. Have you ever previously applied for a Registered Therapist license in Tennessee	____	____
5. Have you ever previously applied for a Respiratory Care Assistant license in Tennessee?	____	____
6. Have you ever received a respiratory care temporary permit in Tennessee?	____	____
7. Are you certified in Polysomnography?	____	____
8. Do you have an ABG endorsement?	____	____

9. If you have an NPI number, please provide: _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments in your profession;

   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

		YES	NO
1.	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice	___	___
2.	Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	___	___
	If so, please list: _____		
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice your profession in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]

COMPETENCY INFORMATION

CONTINUED

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10. Have you ever been rejected or censured by a professional association or society?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	___	___
b. Have you ever entered into any settlement of any legal action; or	___	___
c. Are there any legal actions pending against you or to which you are a party?	___	___
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___
14. Do you have any pending disciplinary charges or action or any current investigation by any disciplinary authority?	___	___

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice in my profession.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____
SIGNATURE **DATE**