ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

RESPIRATORY THERAPY LICENSURE INFORMATION PACKET

This packet contains all of the documents you will need to apply for a license in Arkansas. This packet and each of its components are available on our web site, www.armedicalboard.org. If you received this packet from a source other than directly from the Arkansas State Medical Board or its official website, the application may be outdated or not an official version. Please be advised that outdated or unofficial versions of the application will not be accepted.

*** IMPORTANT INFORMATION - PLEASE READ CAREFULLY ***

ABANDONED APPLICATIONS. Applications which are not complete after twelve (12) months will be classified as Abandoned and will be removed from our system. Abandoned files will be maintained for 30 days and then destroyed. No refunds will be given on abandoned/inactive applications over twelve (12) months old.

APPEARING BEFORE THE BOARD. For your application to be placed on the Board Meeting agenda, it must be complete and all required documentation, including staff investigations, must be in this office. THERE ARE NO EXCEPTIONS TO THIS POLICY. Applicants who have disciplinary actions and/or impairment history may be required to make a personal appearance before the Board. If you are required to make a Board Appearance, you will be notified of the time and date of your appearance prior to the next scheduled Board Meeting.

APPLICATION FEES. The fee for a Respiratory Therapy license is **$75**. Fees must be included with your application at the time of submission. Payment may be made by check or money order payable to *Arkansas State Medical Board - ASMB*.

APPLICATION REVIEW. The application review process is defined by the requirements set forth in state law. The Board and its staff must comply with those laws in processing applications. Applications are processed in the order in which they are received in our office and in the order verifications are obtained. THE BOARD DOES NOT ACCELERATE ONE APPLICANT OVER ANOTHER.

ARKANSAS RESPIRATORY CARE ACT. The Arkansas Respiratory Care Act (Arkansas Code §17-99-101, et seq.) must be read in its entirety prior to submitting an application for a Respiratory Therapy license to the Arkansas State Medical Board. You MUST complete the Rules and Regulations Affidavit included in this packet. Applications received without this form will be returned. The Arkansas Respiratory Care Act is part of the Arkansas Medical Practices Acts & Regulations, which can be viewed and downloaded from our web site, http://www.armedicalboard.org.

CHANGE OF ADDRESS. Regulation 33 requires you to notify the Arkansas State Medical Board of any changes to your address within 30 days of such change. This includes your relocation to Arkansas, if applicable. A change of address form is available for download at our website, www.armedicalboard.org. Any address change MUST BE IN WRITING. The form must be fully completed, signed and dated. Once you are licensed, you may change your address online.

CHECKING THE STATUS OF YOUR APPLICATION. The Arkansas State Medical Board's required form of communication is an interactive Applicant Portal system that allows communication between the Board and the applicant via the web. We have found that this system is a very effective communication tool and significantly reduces the time to licensure once your access identification has been assigned. You may access the Applicant Portal system from any computer at any time by visiting the Medical Board's web site at: http://www.armedicalboard.org.

When using the system, you will see a status bar which will show the percentage completed of your application process. Additional information regarding items that need your attention will be provided to you via a "Click here to respond" link on the "Applicant Portal Home" page. You will need to access your open items by choosing this link and providing a response to the items for which a response is requested.

This interactive system allows the licensing coordinator the time necessary to work your file as opposed to responding to numerous phone calls or e-mails from various interested parties checking on the status of your application. It also allows you to review the progress of your application at any time. You may wish to provide access to your application data to anyone whom you choose; however, once you allow this access, all communication in the system will be viewable. This means that all questions including health or disciplinary issues occurring in other states or institutions will also be viewable.

After all verifications have arrived, your file will be checked to ensure all time gaps have been accounted for in your time line. If they are not, you will be asked to document your activity during those specific times. Although this seems insignificant, it is very important to the Board. This step cannot be skipped.

Once all verifications have arrived and all time gaps filled, your application file will be presented for licensure consideration.

COMPLETING THE APPLICATION. READ THE INSTRUCTIONS FOR EACH QUESTION BEFORE ANSWERING. The application may NOT be submitted electronically or by fax, as we do require your original signature on the hard copy. Please type or print legibly in dark blue or black ink. Provide exact dates (mm/dd/yyyy) whenever possible. ANSWER ALL QUESTIONS/ SECTIONS, even if your answer is "n/a," "Not Applicable," or "None" or "Pending". All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted for documentation or verification purposes. Make sure all required seals are affixed on the application, all questions have a response, and all documentation has been certified. Your application and verifications will be returned to you if they are incomplete or if photos are not attached where required. Pages must be printed on one side only. Two sided (front and back) applications will cause delays due to pages needing to be resubmitted.

CRIMINAL BACKGROUND CHECK. Act 1249 of 2005 authorizes the Arkansas State Medical Board to conduct criminal background checks (both state and federal) on ALL applicants for licensure.
Arkansas Code §17-95-306 states:

(a) (1) Beginning July 1, 2005, every person applying for a license or renewal of a license issued by the Arkansas State Medical Board shall provide written authorization to the board to allow the Arkansas State Police to release the results of a state and federal criminal history background check report to the Board.

(2) The applicant shall be responsible for payment of the fees associated with the background checks.

Upon receipt of your completed application and fee, this office will send you a CBC packet, including forms and instructions. You need to complete and return these forms at your earliest convenience. The Federal portion of this background check can take 4-6 weeks or more to process. ASMB will NOT accept a previously obtained criminal background check, regardless of how recently it was performed or what organization provides it. Payment for the CBC must be made by money order. Complete instructions will be provided in the CBC packet. It is imperative that the completed CBC packet be returned to the Board in a timely manner as failure to do so will delay licensure.

LICENSE RENEWAL. Your Respiratory Therapy license, if granted, must be renewed annually on or before the last day of your birth month. There is no grace period. Your first renewal notification will be sent to you via e-mail 60 days prior to the end of your birth month. A follow up e-mail will be sent at approximately 45 days and a final e-mail notification will be sent 30 days from the last day of your birth month. Failure to receive

notice is NOT considered an excuse for nonrenewal. Failure to renew before midnight on the last day of your birth month will cause your license to automatically expire. If your license expires, you will be assessed a $10.00 late fee to reinstate your license and you will be required to submit copies of your certificates of completion for continuing education units. *******REMINDER ***** It is illegal to practice respiratory therapy in this state on an inactive or lapsed license or permit.**

PROCESSING TIME. Processing delays are almost always attributable to lengthy work histories and delays in receiving the verification documents you request. If you have a history of disciplinary action, impairment history, etc., additional time will be required for our investigation. Processing a permanent license application will take several weeks to complete. Please plan for this. Do not make commitments, purchase a home, or relocate your family before your Arkansas Respiratory Therapy license has been granted. Applications are processed in the order in which they are received in our office and in the order verifications are obtained. The board does NOT accelerate one applicant over another.

SUBMITTING THE APPLICATION. The application may NOT be submitted electronically or by fax, as we do require your original signature on the hard copy and all fees to be paid at submission.

TIME GAPS. Any time gaps of 30 days or more must be explained in writing. You will be notified of any unexplained time gaps and asked to provide an explanation. To avoid processing delays, please include a separate signed explanation of any time gaps of 30 days or more with your original application. Failure to address time gaps may result in delay of licensure.

U.S. POSTAL SERVICE. If you choose to utilize the U.S. Postal Service, please be advised that they do NOT guarantee delivery of first class mail, and they do NOT guarantee delivery of Certified mail. Based on the lengthy delays we have experienced in receiving mail that has been sent to us, we strongly recommend you utilize FedEx, UPS, or other *guaranteed* delivery service when sending your application or other documents to us. We further recommend that when sending verification requests to primary sources, you provide them with a prepaid FedEx, UPS or other delivery service envelope to ensure that their correspondence reaches us in a timely manner.

VERIFICATIONS. It is the policy of this board that ALL education and professional affiliations and other activities since graduation from Respiratory Therapy school (or within the past five years whichever is less) be verified by the primary source prior to issuance of a permanent license. It is the applicant's responsibility to request verifications and to follow up with organizations to ensure verifications are provided to the Board. Applicants are required to sign verification documents where indicated in Part II prior to sending to the verification source. The verifier's signature can be original, stamped or computer-generated. All verifications can be faxed or e-mailed unless specifically requested to be mailed. To fax, send to (501) 296-1972, Attn: Licensing. To e-mail, the document must be attached as an Adobe PDF file and sent to support@armedicalboard.org with "Attn: Licensing" in the subject line. Note that if the attachments are not sent in this format and to this address, they will be stripped at the firewall and will not be received by the intended recipient.

WITHDRAWN APPLICATIONS. Applications which are withdrawn by the applicant will be maintained for 30 days and then destroyed. No refunds are given on applications that are withdrawn.

"YES" RESPONSES. A "Yes" response in the attestation portion of the application does not mean your application will be denied. If you have responded "Yes" to any of these questions, additional time will be required for the gathering and assessment of pertinent information. You will be required to provide a separate, signed and complete explanation for each "Yes" response; you can expedite this process by including these with your original application. Failure to appropriately answer questions may result in an appearance before the Board for full licensure; disciplinary action; and/or denial of a license.

RESPIRATORY THERAPY REQUIREMENTS FOR LICENSURE IN ARKANSAS

LICENSURE REQUIREMENTS:

(1) Be at least 18 years of age;
(2) Be of good moral character;
(3) Complete a background check;
(4) Have been awarded a high school diploma or its equivalent;
(5) Have satisfactorily completed training in a respiratory care program which has been approved by the Respiratory Therapy Examining Committee, to include adequate instruction in basic medical science, clinical science, and respiratory care theory and procedures;
(6) Have passed the CRT exam;
(7) Submit a completed application and all required forms with a licensure fee of $75;
(8) Present undisputable identification.

LICENSURE IS BY CREDENTIALS:

- Credentials must be verified from the originating source.

LICENSING EXAMINATIONS THAT MEET THE BOARD'S REQUIREMENTS:

- NBRC

LICENSE APPLICATION CHECKLIST

(Use this checklist to be sure your application is complete prior to sending to the Arkansas State Medical Board)

USE THE FOLLOWING ADDRESS FOR ALL DOCUMENT SUBMISSION:

ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING
1401 WEST CAPITOL AVE., SUITE 340
LITTLE ROCK, AR 72201

You are required to provide the following documents to the Arkansas State Medical Board:

- ☐ Check or money order, made payable to *ASMB*, in the amount of $75;
- ☐ Completed Application signed, with passport-style photo attached and certification by Notary Public. Signature must be original and must be made in black or dark blue ink. Stamped signatures, signatures by proxy and signatures by Power of Attorney are NOT accepted; Do not complete the application on front and back pages. Use one sided pages only.
- ☐ Signed and dated explanations for any "Yes" answers in Part IV of the Application, with applicable supporting documentation;
- ☐ Signed and dated explanations for any time gaps of 30 days or more since the end of undergraduate education;
- ☐ Completed Respiratory Therapy Authorization and Release (form in packet);
- ☐ Completed Arkansas Medical Practices Acts and Rules and Regulations Affidavit (form in packet);
- ☐ Copy of Driver's License or Passport;
- ☐ Copy of name change documents, if applicable;
- ☐ Copy of proof of citizenship, naturalization or visa, if applicable *(if not born in the U.S.);*
- ☐ Copy of DD Form 214 (Certificate of Release or Discharge from Active Duty), if you have served in any branch of the U.S. Armed Forces at any time since respiratory therapy school;
- ☐ Copy of current résumé.

YOU are required to request the following documents from their primary sources, and these documents must be sent from the primary source DIRECTLY to the Arkansas State Medical Board.

- ☐ **NBRC Credential Verification** (if you have taken and passed the examination)
  Go to www.nbrc.org to request a verification of credential be sent directly to this office.
- ☐ **Verification of Education and Official Transcript** (form in packet)
  Complete Parts I and II of this form and send to the Dean or Registrar of the respiratory therapy school/program you attended. The completed form and transcript must be sent directly from the source to this office.

- ❑ **Verification of Licensure** (form in packet)
  Board staff will obtain these for you online once your application is in process. However, in the event a state does not offer the license verification online, if there is a fee, or the website has not been updated, the applicant will be responsible for requesting and paying any fees. The ASMB must have verification of all licenses ever held, even temporary licenses from other states, whether active or inactive.

- ❑ **Verification of Hospital/Facility Affiliation** (form in packet)
  Complete Parts I and II of this form, and then send to the Department Director or Administration Office of every facility that has granted you Respiratory Therapy privileges or has employed you as a Respiratory Therapist in the last five (5) years or since graduating from respiratory therapy school, whichever is shorter. The completed form or an equivalent verification letter must be sent directly from the source to this office.

- ❑ **Verification of Military Service**
  If you are still in the armed forces, request that your current Commanding Officer submit a verification letter directly to this office. If you are former military, you only need to provide a copy of your DD Form 214 if you have served since graduating respiratory therapy school.

- ❑ **Verification of Employment (Non-Therapy)** (form in packet)
  Complete Parts I and II of this form, and then send one to the appropriate department at each place you have worked that is non-therapy-related within the last five (5) years, or since graduating from respiratory therapy school, whichever is shorter. The completed form or an equivalent verification letter must be sent directly from the source to this office. Note: For retail jobs, including restaurants, an itemized list is sufficient; if it is determined verification is needed, you will be notified.

- ❑ **Physicians Health Committee Documents**
  If you are now being or have ever been monitored by a Physician Health Committee in any state or country, ask the director of that program to furnish a copy of your contract and a letter verifying your status. If you are currently under a PHC contract, you must also contact the Arkansas Physicians' Health Committee:

  Arkansas Physicians' Health Committee
  Arkansas Medical Foundation
  10 Corporate Hill, Suite 150
  Little Rock, AR 72205
  (501) 224-9911

INSTRUCTIONS FOR COMPLETING LICENSURE APPLICATION

1. READ ALL INSTRUCTIONS.
2. Type or print legibly in dark blue or black ink all application documents. (One sided documents only.)
3. Provide exact dates (mm/dd/yyyy) whenever possible.
4. ANSWER ALL QUESTIONS/SECTIONS, even if your answer is "n/a," "Not Applicable," "None," or "Pending."
5. Give careful thought to each question before answering. Remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Part IV of the application, you must attach a signed and dated explanation.
7. Failure to answer all questions completely and accurately, or the omission or falsification of information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. WHEN IN DOUBT, DISCLOSE AND EXPLAIN ALL INFORMATION.
8. All signatures must be the applicant's; stamped signatures, signatures by proxy, and signatures by power of attorney are NOT accepted.

Question 1: Your Name

a. Enter your legal name as listed on your driver's license. If your name has changed due to marriage, divorce, adoption or naturalization, submit a copy of the pertinent documentation.
b. Enter any other names used during your education or career, such as maiden name, nicknames, etc.

Question 2: Your Identification

a. Enter your social security number.
b. Enter your driver's license number and state abbreviation. *Send a copy of your driver's license with your license application.*
c. Check male or female.
d. Enter your date of birth (mm/dd/yyyy).

Question 3: Birthplace/Citizenship

a. Enter your place of birth (city and state or city and country).
b. Enter the name of the country in which you hold citizenship. *If you are a U.S. citizen but you were born in a foreign country, you must submit proof of citizenship.*
c. Indicate your immigration status. If you are a U.S. citizen, enter "n/a". *If you are not a U.S. citizen, you must submit a copy of your current Visa.*
d. Indicate how long you have lived in the U.S. If you are a U.S. citizen, enter "n/a".
e. Indicate your ethnicity by checking the appropriate box.
f. Indicate your race by checking the appropriate box.

Question 4: Your Contact Information (Both address sections must be completed, even if they are the same.)

a. Enter your Public mailing address. **This field is required.** This address appears on all printed reports, bulk data listings, the Online Directory and the free, online license verification system. It is also available to the general public under Freedom of Information, and all other reports available to the credentialing organizations utilizing the ASMB website for license and/or credentials verification.
b. Enter your Private mailing address. **This field is required.** The Private address is used to send renewal reminders, direct and confidential communication from the Board and the Board's quarterly Newsletter. It is NOT available to the public under Freedom of Information ***unless*** you also use this address as your public address.
c-f. Enter your private, work, fax, and mobile phone numbers in the appropriate spaces.
g. Enter your personal e-mail address. **Your personal e-mail address is required.** This is the e-mail address through which you will receive automated system messages as to the status of your application. You may also receive private and confidential e-mails for clarification purposes from the licensing staff. This is NOT your primary contact's e-mail address, as this e-mail address will carry over towards the required online renewal setup.

Question 5: Intended Practice Location

a. Enter the name of the hospital, clinic, group or private practice where you will be practicing in Arkansas. If you have not yet found employment, enter "Unknown."
b. Enter the mailing address of the hospital, clinic, group or private practice where you will be practicing. If you have not yet found employment, enter "Unknown."

Question 6: Education

a. Enter the full name of the respiratory therapy school/ program where you completed your undergraduate and graduate (if applicable) education. *Complete Parts I and II of the "Verification of Respiratory Therapy Education" form contained in the application packet and send one to the school. This form should only be completed and submitted after graduation; any forms submitted before graduation are invalid and must be submitted again.* Forms must be returned directly to this office from the institution.
b. Enter the mailing address of the school/program.
c. Enter the date you started attending the school/ program.
d. Enter the date you graduated from the school/ program.
e. Answer "Yes" if you graduated, "No" if you did not graduate.
f. Enter the degree you were awarded.

Question 7: Examinations

a. Specify which exams you have taken (TMC, CRT, RRT, NPS, CPFT, RPFT or SDS).
b. Enter the number of times you took the exam.
c. Enter the number of times you failed the exam.
d. Enter the date you passed the exam. If you have not taken and passed the exam, write "n/a" and s*end a copy of the Eligibility to Examine Notice to our office. If you have passed the CRT exam, request the Credential Verification from NBRC be submitted directly to our office.*

Question 8: Licenses

a. If you have never held a respiratory therapy license (including a temporary or training permit) in another state or country, enter "None" in the first space and proceed to Question 9. If you have ever held a respiratory therapy license in another state or country, enter the name of that state or country here.
b. Enter your respiratory therapy license number.
c. Enter the date the respiratory therapy license was originally issued.
d. Enter the date the respiratory therapy license expired or will expire.
e. Enter "Yes" if this license is still active, "No" if it is not.

Question 9: Military Service

a. Answer "Yes" if you have ever served in the armed forces of the U.S. or any other country since graduating respiratory therapy school. Answer "No" if you have not. *If yes, send a copy of your separation papers (DD Form 214) with your application. If Active Duty or Active Reserves, you must have your current Commanding Officer submit a verification letter directly to this office OR complete Parts I and II of the "Verification of Current Military Service" form and send it to the appropriate department in the United States military for them to complete and return to this office. Verifications must be returned from the source to this office.*
b. Enter the country and branch you served.
c. Enter the date you entered the armed forces.
d. Enter the date you were discharged from the armed forces.
e. Enter the type of discharge you received (Honorable, General, etc.)

Question 10: Work History

a. Enter the name of your employer. You must list all professional activities since graduation from respiratory therapy school. Do NOT enter "See résumé". If you ever took a leave of absence of more than 30 days from an employer, or if there was a gap of 30 days or more between the end of one activity and the beginning of the next, you must provide a separate, signed and dated explanation for the time gap. *Complete Parts I and II of the "Verification of Hospital/Facility Affiliation" and send one to the appropriate department at each hospital, clinic, group or private practice where you worked as a Respiratory Therapist within the past five (5) years. Complete Parts I and II of the "Verification of Employment (Non-Therapy)" and send one to the appropriate department at each place you have worked that is non-therapy-related within the past five (5) years or since graduating from respiratory therapy school, whichever is shorter. Verifications must be returned directly from the source to this office.*
b. Enter the mailing address of the employer. *If the facility is closed, enter the last known address and indicate the facility is closed.*
c. Enter the date your employment began.
d. Enter the date your employment ended.
e. Enter your title or position with this employer.
f. Enter your current status with this employer (Active or Inactive).

QUESTIONS 11-18 (ATTESTATION QUESTIONS):

For each "YES" response to questions 11 through 18, you must provide a separate, signed and dated statement giving full details, including date, location, type of action, organization or parties involved, and specific circumstances. If you are not sure how to respond to a question, it is best to disclose all information and provide an explanation. Failure to answer these questions accurately may result in disciplinary action or denial of license. If, during the application process, you become aware of any investigation, action, or other circumstance relating to questions asked in this section, you are required to report it to this office.

FOR QUESTIONS 11 and 12:

If you answer "yes" to either of these questions, in addition to the written explanation outlined above, you must also attach a copy of the charging document, judgment or conviction, indicate whether paroled or placed on probation, and how probation was completed for any arrest/charge in the past 10 years. **If you have or had a record that was sealed, expunged or pardoned, <u>you are still required to answer "Yes" to this question</u>**.

Affidavit of Applicant (Signature Page):

Read the affidavit completely before signing. Insert the applicant's name in the blank. Attach a passport-style photo, taken within the past sixty (60) days, in the space shown. You must sign where indicated IN THE PRESENCE OF A NOTARY PUBLIC, swearing you are the person referred to in the application and that all statements contained therein are true and correct. The Notary seal should be affixed below the photograph. The Notary's date must match your signature date. *Applications received without a photo or the required Notary seal will be returned to the applicant for completion, thereby delaying the application process.*

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APPLICATION FOR RESPIRATORY THERAPY LICENSURE IN ARKANSAS

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents. (One sided documents only.)
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each question before answering; remember, you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Part IV of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately, or the omission or falsification of information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. WHEN IN DOUBT, DISCLOSE AND EXPLAIN ALL INFORMATION.

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)			
1b. Other Names Used (including Maiden Name)			
2a. Social Security Number	2b. Driver's License State & Number	2c. Gender ☐ Male ☐ Female	2d. Date of Birth (mm/dd/yyyy) / /
3a. Place of Birth (City and State/Country)		3b. Country of Citizenship	
3c. Immigration Status (if not U.S. citizen)		3d. How long have you been in the U.S.? (if not U.S. citizen)	
3e. Ethnicity ☐ Non-Hispanic ☐ Hispanic		3f. Race ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander	
4a. Public Address (Street, City, State, Zip Code)			
4b. Private Address (Street, City, State, Zip Code)			
4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #
4g. Personal E-mail Address			
5a. Intended Practice Location in Arkansas: Full Name Hospital, Clinic, Group or Private Practice			
5b. Mailing Address of Intended Practice Location (PO Box or Street, City, State, Zip Code)			

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Application Received: / /	Fee Received: $	PHIDNO:	
LRCP License #:	Full License Issued: / /		

PART II - EDUCATION

UNDERGRADUATE AND GRADUATE EDUCATION — List all respiratory therapy schools/programs you attended (attach additional sheets if necessary). Have each school complete and submit the Verification of Education form and official transcript directly to this office.

6a. Full Name of Institution and Program			
6b. Mailing Address (Street Address, City, State, Zip Code)			
6c. Start Date / /	6d. End Date / /	6e. Graduated? ☐ Yes ☐ No	6f. Degree Awarded, or reason why you did not graduate
6a. Full Name of Institution and Program			
6b. Mailing Address (Street Address, City, State, Zip Code)			
6c. Start Date / /	6d. End Date / /	6e. Graduated? ☐ Yes ☐ No	6f. Degree Awarded, or reason why you did not graduate

EXAMINATION HISTORY — Please specify exam (TMC, CRT, RRT, NPS, CPFT, RPFT or SDS). Attach additional sheets if necessary. Have NBRC (National Board of Respiratory Care) send a verification letter directly to this office if you have passed the CRT exam.

Have you passed the NBRC exam? ☐ Yes ☐ No

7a. Exam	7b. Number of Attempts	7c. Number of times failed	7d. Date PASSED / /
7a. Exam	7b. Number of Attempts	7c. Number of times failed	7d. Date PASSED / /
7a. Exam	7b. Number of Attempts	7c. Number of times failed	7d. Date PASSED / /
7a. Exam	7b. Number of Attempts	7c. Number of times failed	7d. Date PASSED / /

PART III - PROFESSIONAL

PROFESSIONAL LICENSURE — List all states or territories of the United States, provinces of Canada, or other countries in which you hold or have ever held a Respiratory Therapy license, including all temporary, instructional and training permits/licenses. Attach additional sheets if necessary.

8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)
8a. Jurisdiction (State, Country)	8b. License No.	8c. Issue Date / /	8d. Expiration Date / /	8e. Active? (Yes/No)

MILITARY SERVICE — Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

9a. Have you ever been in the armed forces since graduating from respiratory therapy school?
☐ Yes ☐ No *If yes, complete questions 9b-9e.*

9b. Country & Branch of Service	9c. Date of Entry / /	9d. Date of Discharge / /	9e. Type of Discharge

WORK HISTORY	Please provide a chronological listing of all therapy and non-therapy work history and other activities, institutional affiliations or places of employment since graduation from respiratory therapy school. This includes hospitals, private practice, and employment assignments. **You must provide explanations of any time gaps and leaves of absence of 30 days or more since graduation from respiratory therapy school. Do not write, "See résumé." If you need more space, additional sheets may be attached.**		
10a. Name of Institution/Facility/Employer			
10b. Mailing Address (Street or PO Box, City, State, Zip Code)			
10c. Date From / /	10d. Date To / /	10e. Title/Position	10f. Status
10a. Name of Institution/Facility/Employer			
10b. Mailing Address (Street or PO Box, City, State, Zip Code)			
10c. Date From / /	10d. Date To / /	10e. Title/Position	10f. Status
10a. Name of Institution/Facility/Employer			
10b. Mailing Address (Street or PO Box, City, State, Zip Code)			
10c. Date From / /	10d. Date To / /	10e. Title/Position	10f. Status
10a. Name of Institution/Facility/Employer			
10b. Mailing Address (Street or PO Box, City, State, Zip Code)			
10c. Date From / /	10d. Date To / /	10e. Title/Position	10f. Status
10a. Name of Institution/Facility/Employer			
10b. Mailing Address (Street or PO Box, City, State, Zip Code)			
10c. Date From / /	10d. Date To / /	10e. Title/Position	10f. Status

PART IV - ATTESTATION QUESTIONS

SPECIAL INSTRUCTIONS FOR QUESTIONS 11-18

- Please mark the appropriate box next to each question. Do not leave any questions blank.
- For each "Yes" response to questions **11-18**, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances. **If you are not sure about how to respond to a question, it is best to disclose all information and provide an explanation.**
- Failure to answer these questions accurately may result in disciplinary action or denial of license.
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

11.	Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: **You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed**.) *If yes, explain.*	☐ No ☐ Yes
12.	Have you **ever** been cited, arrested, charged or convicted of DWI (driving while intoxicated) or DUI (driving under the influence)? If yes, explain.	☐ No ☐ Yes
13.	Do you have any physical, mental or emotional impairment that has the potential to hinder your ability to perform duties assigned in any healthcare profession including that of Respiratory Therapy? *If yes, explain.*	☐ No ☐ Yes
14.	Have you ever been addicted to alcohol or drugs? *If yes, explain.*	☐ No ☐ Yes
15.	Have you ever been treated for alcohol/substance abuse in a treatment center or hospital? *If yes, give name of institution, date and length of stay in your explanation.*	☐ No ☐ Yes
16.	Has any medical or respiratory care licensing board or NBRC ever sanctioned you or your certification? *If yes, list name and address of board/entity in your explanation.* **If, during the application process, you become aware of any such investigation, you are required to report it to this office.**	☐ No ☐ Yes
17.	Have you ever voluntarily surrendered your respiratory care license in any other jurisdiction, state or territory? *If yes, give name and address of board in your explanation.*	☐ No ☐ Yes
18.	Have you ever previously made application to the Arkansas State Medical Board? *If yes, explain.*	☐ No ☐ Yes

continue to next page

DO NOT WRITE EXPLANATIONS IN THIS SPACE.

PART V - AFFIDAVIT OF APPLICANT

I, _____, hereby certify, after being duly sworn, that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice as a Respiratory Therapist in the State of Arkansas.

AFFIX
PASSPORT-STYLE
PHOTOGRAPH
HERE

_____

Applicant's Signature (in ink)
(must be signed in the presence of a Notary Public)

_____

Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of _____, this _____ day of _____, 20 _____.
(Notary date must be the same as the applicant's signature date above)

My commission expires: _____

_____

Notary Signature
(Notary seal must be below the photograph at left)

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT AND RULES & REGULATIONS AFFIDAVIT

Respiratory Therapist

I AFFIRM THAT I HAVE READ THE RESPIRATORY CARE ACT, ARKANSAS CODE ANNOTATED §17-99-101, *et seq.*, AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

_____
Practitioner's Full Name (First Middle Last, Suffix, Degree)

_____
Practitioner's Signature (no rubber stamps)

_____
Signature Date

THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED FORM.

YOU MUST COMPLETE THIS FORM AND RETURN IT WITH YOUR APPLICATION TO:
ARKANSAS STATE MEDICAL BOARD
1401 WEST CAPITOL AVE, SUITE 340
LITTLE ROCK, AR 72201

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 www.armedicalboard.org
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any healthcare practitioners with whom I have been associated; employees and medical staff members of any medical facility or hospital where I have been employed, on staff, or associated; any employees of any malpractice insurance carriers; any state licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Practitioner: _____

Social Security Number: _____

Signature of Practitioner: _____
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: _____

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SECONDARY CONTACT DESIGNATION FORM

So that the licensing process might be made easier for both you and the Board, your Licensing Coordinator will communicate with you and ONE other person of your choice regarding the status of your licensure application. However, please advise your designated contact that your Licensing Coordinator is working with several other applicants at any given time, and that repeated phone calls to check on the status of your application will only delay the processing time for all applicants. We appreciate your consideration of this.

- This form is optional. If you do not choose to list a secondary contact designation, this form is not required.

I authorize the Arkansas State Medical Board to release any and all information regarding the status of my licensure application to the person listed below:

_____
Print full name of Secondary Contact

_____
Organization Name

_____
E-mail address of Secondary Contact

_____
Phone number of Secondary Contact

_____
Print full name of Applicant

_____
Signature of Applicant (no signature stamps)

_____
Date Signed

If you desire to utilize a secondary contact, this document must be completed and returned with your initial application. Information regarding your licensure application will not be released to anyone other than you without this written authorization. If you choose to utilize a designated contact, that person will be copied on all correspondence sent from this office regarding your application.

ARKANSAS STATE MEDICAL BOARD

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Documents submitted by email must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: .....

VERIFICATION OF RESPIRATORY THERAPY EDUCATION

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – INSTITUTION NAME AND MAILING ADDRESS

Institution Name: .....
Department or Office: .....
Address Line 1: .....
Address Line 2: .....
City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
Other Names Used		Date of Graduation (mm/dd/yyyy) / /
AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY DEAN, REGISTRAR or AUTHORIZED REPRESENTATIVE ONLY)

Please complete the information below (or your equivalent verification letter) and return **with an official transcript directly to the Arkansas State Medical Board.** Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Respiratory Therapy School (if not correct above)		
Date R.T. Education Began / /	Date R.T. Education Ended / /	Degree Awarded (ex: Associate of Applied Science) ❒ None
If program was not completed, or was completed in more or less than the customary time frame for such training, please provide explanation (use additional sheets if necessary).		
During this applicant's education, was he/she ever investigated or disciplined by the school for any reason? ❒ Yes ❒ No *[Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide a detailed explanation on a separate sheet, signed and dated by the person whose signature appears below.]*		

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name		Position/Title
Phone Number	Fax Number	E-mail Address

PLEASE RETURN THIS FORM WITH AN OFFICIAL TRANSCRIPT
DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Documents submitted by email must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: .....

VERIFICATION OF LICENSURE

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – LICENSING AUTHORITY NAME AND MAILING ADDRESS

Name of Licensing Authority: .....
ATTN: .....
Address Line 1: .....
Address Line 2: .....
City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
Other Names Used		License Number for this state or country

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Applicant Signature (no electronic or stamped signature)	Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY LICENSING AUTHORITY STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

State/Country	Name of Licensing Authority (if not correct above)	
License Number	Original Issue Date (mm/dd/yyyy) / /	Expiration Date (mm/dd/yyyy) / /

Current License Status
❒ Active ❒ Inactive ❒ Temporary ❒ Other:_____

License Category
❒ Unlimited ❒ Educational ❒ Other:_____

Please answer the following questions and attach explanations and dates for any "Yes" answers.

Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending?	❒ Yes	❒ No
Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending?	❒ Yes	❒ No
Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state, or is any such action pending?	❒ Yes	❒ No

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name		Position/Title
Phone Number	Fax Number	E-mail Address

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL
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LRCP FORM: Verification of Licensure (10/29/10 QI; Rev. 4/18/12 QI; 12/31/13 BLE; 10/8/15 BLE; 3/2017 KDW)

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DATE OF REQUEST: .....

VERIFICATION OF HOSPITAL/FACILITY AFFILIATION

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – FACILITY NAME AND MAILING ADDRESS

Name of Facility: .....

ATTN: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
Other Names Used		
AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY FACILITY AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Facility (if not correct above)		
Current Staff Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Affiliation Began (including temp or provisional) / /	Date Affiliation Ended / /	❒ If exact dates are not available, please check here. If currently appointed, please write "Present" in the space for end date.
Note: Breaks in appointment should be listed as separate entries. If the applicant was there intermittently, a listing of each time period he/she was appointed to your facility's ancillary staff should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing appointment dates.		
Current or most recent Position/Title		
To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed). ❒ Yes ❒ No ❒ Unknown/Unable to comment, Reason:		

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name		Position/Title
Phone Number	Fax Number	E-mail Address

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

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DATE OF REQUEST: .....

VERIFICATION OF EMPLOYMENT (Non-Therapy)

(for verification of employment that did not involve respiratory therapy)

PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: .....

ATTN: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX-XX- ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.		
Applicant Signature (no electronic or stamped signature)		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)		
Employment Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Employment Began / /	Date Employment Ended / /	❒ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.		
Current or Most Recent Position/Title		
To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed). ❒ Yes ❒ No ❒ Unknown/Unable to comment, Reason:		

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name		Position/Title
Phone Number	Fax Number	E-mail Address

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ARKANSAS STATE MEDICAL BOARD

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Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: .....

VERIFICATION OF CURRENT MILITARY SERVICE

PART I AND PART II TO BE FILLED OUT BY THE APPLICANT – REQUIRED FOR VERIFICATION TO BE ACCEPTED

PART I – MILITARY NAME AND MAILING ADDRESS

Name of Duty Station: .....

Name of Current Commanding Officer: .....

Address Line 1: .....

Address Line 2: .....

City, State, ZIP Code: .....

PART II – APPLICANT INFORMATION

Full Name (Last, First, Middle)	Social Security Number XXX – XX – ___ ___ ___ ___	Date of Birth (mm/dd/yyyy) / /
AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.		
Applicant Signature		Date Signed (mm/dd/yyyy) / /

PART III – VERIFICATION (TO BE COMPLETED BY AUTHORIZED PERSONNEL ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the applicant cannot be accepted for verification purposes. Provide exact dates if possible.

Branch of Service		
Present Status ❒ Current ❒ Inactive ❒ Leave of Absence ❒ Other _____		
Date Service Began / /	Date Service Ended / /	❒ If exact dates are not available, please check here. If currently in the military, write "Present" in the space for end date.
Current or Most Recent Position/Title		
To your knowledge, during the stated period of time, was the applicant in good standing? If No, please explain (attach additional sheets if needed). ❒ Yes ❒ No ❒ Unknown/Unable to comment		

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date / /
Type or legibly print name	Position/Title	
Phone Number	Fax Number	E-mail Address

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

Inactive U.S. military personnel should provide proof of service by submitting a copy of his/her DD Form 214 with their application in lieu of completing this form.