

STATE OF ARIZONA APPLICATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER

Please read the instructions which accompany this application form before completing any of the following sections. **INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED FOR LICENSURE.** Failure to submit fees at time of application constitutes an incomplete application. The application fee is non-refundable. All applications must be accompanied by the proper documentation (i.e. NBRC Certificate, Certificate of Completion from an AMA approved training program, fingerprint card, criminal court documents and any documentation of name changes). Any questions related to this application, please contact the Board office at www.rb.az.gov

APPLICANT INFORMATION

Name: (first, middle, last)

Mailing Address:

City:	State:	Zip Code:
-------	--------	-----------

Permanent Address: (if different from above)

City:	State:	Zip Code:
-------	--------	-----------

Home Phone:	Cell Phone:
-------------	-------------

Date of Birth:	S.S.N.:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
----------------	---------	---

Height:	Weight:	Aliases:
Hair:	Eyes:	

Email:

STATUS DECLARATION

Where were you born? (List City, State (or equivalent) and Country)

City:	State:	Country:
-------	--------	----------

Citizen or National of the United States? Yes No

• **If the answer is “Yes”** to the Citizen or National of the U.S., please continue onto the employment section.

• **If the answer is “No”** to the Citizen or National of the U.S., the following must be answered:

“Qualified Alien” Status:

- An alien lawfully admitted for permanent residence under the Immigration and Nationality Act
- An alien who is granted asylum under Section 208 of the INA.
- A refugee admitted to the United States under Section 207 of the INA.
- An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.
- An alien whose deportation is being withheld under Section 243(h) of the INA.
- An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
- An alien who is a Cuban and Haitian entrant (as defined in Section 5019e) of the Refugee Education Assistance Act of 1980.)
- An alien who has, or whose child or child’s parent has, been declared a “battered alien” or an alien subject to extreme cruelty in the United States.

“Nonimmigrant” Status:

- An alien not in categories (listed on the previous page) who have been admitted to the United States for a Limited period of time (a nonimmigrant). (Nonimmigrants are persons who have temporary status for a specific purpose.)
 - If you checked the above item, please answer the following:
 - Does the applicant have a nonimmigrant visa for entry that is related to employment in the United States for which the applicant is applying for a license?
 - Yes No

Alien paroled into the United States for less than one year:

- An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA.

**STATE OF ARIZONA
APPLICATION FOR LICENSURE
AS A RESPIRATORY CARE PRACTITIONER**

Please read the instructions which accompany this application form before completing any of the following sections. INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED FOR LICENSURE. Failure to submit fees at time of application constitutes an incomplete application. The application fee is non-refundable. All applications must be accompanied by the proper documentation (i.e. NBRC Certificate, Certificate of Completion from an AMA approved training program, fingerprint card, criminal court documents and any documentation of name changes). Any questions related to this application, please contact the Board office at www.rb.az.gov

EMPLOYMENT INFORMATION

Current employer:		
Employer address:		
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
Position:	Area of care/specialty:	Employment Start Date: End Date(if not current):

EDUCATION/CERTIFICATION

Are you NBRC certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		(Attach copy of NBRC certificate)
<input type="checkbox"/> CRT :	(date certified)	<input type="checkbox"/> RRT (date certified)
Name of AMA approved or equivalent Respiratory Care Training: <small>(Attach Copy of degree/diploma received.)</small>		Training Completion Date:
Address:		Phone:
City:	State:	Zip Code:
Highest Level of Education Completed: <input type="checkbox"/> Vocational/Respiratory <input type="checkbox"/> Associate <input type="checkbox"/> Baccalaureate <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate		Date of Completion/Graduation:

OTHER STATE PROFESSIONAL LICENSES

Name all states (include license numbers and expiration dates) in which you currently hold or have ever held a license to practice respiratory care:

State:	License #:	Expiration Date:
State:	License #:	Expiration Date:
State:	License #:	Expiration Date:
State:	License #:	Expiration Date:

STATE LICENSURE HISTORY

For the following four questions, if you answer yes, attach a complete explanation including dates, places, and a copy of any order issued.

Have you ever been denied a license or certificate, or the privilege of taking an examination by any governing licensing agency/board in this state or elsewhere:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you the subject of any pending disciplinary action(s) or a subject of discipline, censure, probation, practice restriction, suspension, revocation or cancellation, directly or indirectly related to your Respiratory Care Practitioner license in any state:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever voluntarily surrendered a professional license:	<input type="checkbox"/> Yes <input type="checkbox"/> No

**STATE OF ARIZONA
APPLICATION FOR LICENSURE
AS A RESPIRATORY CARE PRACTITIONER**

Please read the instructions which accompany this application form before completing any of the following sections. **INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED FOR LICENSURE.** Failure to submit fees at time of application constitutes an incomplete application. The application fee is non-refundable. All applications must be accompanied by the proper documentation (i.e. NBRC Certificate, Certificate of Completion from an AMA approved training program, fingerprint card, criminal court documents and any documentation of name changes). Any questions related to this application, please contact the Board office at www.rb.az.gov

STATE LICENSURE HISTORY CONTINUED

Have you previously filed an application for a Respiratory Care Practitioner's license in the State of Arizona?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Please Note: You are required to send each state in which you currently hold or have ever held a license to practice respiratory care an Arizona Out-of-State Verification form to each licensing agency.

PERSONAL HISTORY INFORMATION

For the following four questions, if you answer yes, attach a complete explanation including dates, places, and a copy of any and all letter of completions and court documents.

Have you ever enrolled in or been committed to a substance abuse program in the last ten years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Omitting minor traffic violations (infractions), have you ever been convicted of, or plead no contest (nolo contendere) to, entered into any agreement concerning arrest or charge (even if the agreement resulted in dismissal or expungement), or have an outstanding arres or charge for any violation of any law of any state of the United States, or a foreign country? This includes all Misdemeanors and Felonies. Any conviction which has been expunged under Title 13, section 1203, of the Arizona Penal Code (or similar state or federal statue) must be disclosed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Have you ever had any habitual intemperance to drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

AFFIDAVIT

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies (local, State, Federal, or foreign) to release to the Board of Respiratory Care any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Respiratory Care to release information contained in this application in association with its processing.

Also, I understand that I must abide by the rules and statutes for licensing in Respiratory Care as defined in the Laws and Regulations issued by Arizona State Board of Respiratory Care and by the Arizona Revised Statutes and Rules issued by the Arizona State Board of Respiratory Care.

I certify upon penalty of perjury under the laws of the State of Arizona, that the document enclosed (Application for Licensure as a Respiratory Care Practitioner) is a true and correct copy of the original received by me. I further certify that any additional materials enclosed are true and correct copies of originals received by me and are originals issued to me.

Print Name:	Signature:	Date:
-------------	------------	-------