PRACTITIONER OF RESPIRATORY CARE APPLICATION FOR REGISTRATION RENEWAL FOR THE BIENNIAL REGISTRATION PERIOD 2019 – 2021 NEVADA STATE BOARD OF MEDICAL EXAMINERS

Phone: (775) 688-2559 Address: 9600 Gateway Drive Reno, Nevada 89521

Date Received by Board	
	License No
	File No.
	(For Board Use Only)

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

ACTIVE STATUS ----- \$215.00

SAVE \$20 by renewing online at medboard.nv.gov.

Make checks payable to:

NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. Funds.")
Credit card authorization may also be utilized.

PLEASE NOTE THE FOLLOWING IMPORTANT INSTRUCTIONS REGARDING YOUR APPLICATION:

- Your current practitioner of respiratory care license expires on <u>JULY 1, 2019</u>. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by JULY 1, 2019, at 5:00 p.m. PDT, your license will be automatically expired and you will not be able to work as a practitioner of respiratory care until you reinstate your license. <u>NEVADA HAS NO GRACE PERIOD</u>.
- Your license will not be renewed unless you answer <u>ALL</u> questions on this application and provide written explanation(s) for any/all question(s) answered "yes."
- Your license will not be renewed until the Board receives your original signed Application for Registration Renewal form. A faxed copy is not acceptable.
- Your license will not be renewed unless it is accompanied with a check for the proper fee or credit card authorization.
- You may have been selected in a random continuing education (CE) audit of all licensees. If you were randomly selected, you will be contacted by the Board for proof of your CE. Your license will not be renewed if you do not have proof of the required CE. Refer to page 4 for a review of your CE requirement. Please retain proof of your CE as the Board does not retain copies.
- Your license will not be renewed unless you attach a copy of proof of your current National Board for Respiratory Care (NBRC) certification.
- All information provided on this application is PUBLIC information.
- PLEASE TYPE OR PRINT LEGIBLY.

Please print your name and address clearly in the space provided below. Be advised that the address you provide below is viewable on the Board website and is listed as the <u>public</u> address. Also, please provide your current <u>public</u> telephone and fax numbers. [Note: If your name has changed, a copy of the document authorizing your legal name change (marriage license, divorce decree, etc.) must be included.]

Name			
Street			
City	County	State	
Zip			
Phone Number		Cell Phone Number	
Fax Number		e-mail address	

In the event that you were selected in the random audit, providing an e-mail address will greatly assist the Board to expedite communication for your renewal.

QUESTIONS

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical
- 2. 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
- 3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

 $\textbf{``Medical condition''} \ \ \text{includes physiological, mental or psychological condition or disorder}.$

"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.

Please answer all of the following questions for the time period July 1, 2019 – July 1, 2019, or since your last renewal.

For all YES responses to the following questions, you must submit your written explanation(s) on a separate sheet attached to this form.

1.	Do you currently have a medical condition that in any way impairs or limits your a services with reasonable skill and safety?	ability to -	provide resp Yes	iratory care No
2.	If you currently have a medical condition which in any way impairs or limits your services, is that impairment or limitation reduced or ameliorated because of the manner in which you have chosen to practice, or by any other reasonable accommodates accommodate to the condition of the condition o	field of p	bractice, the	
		_Yes _	No	N/A
3.	If you currently use chemical substances, does your use in any way impair or limit	-		
	care services with reasonable skill and safety?	_Yes _	No	N/A
4.	Have you been named as a defendant, or been requested to respond as a defe professional liability, or malpractice, including any military tort claims if applicable		•	on involving No
5.	Have you had a professional liability, malpractice, claim paid on your behalf, or pa any military tort claims if applicable?		claim yourse Yes	elf including No
6.	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or violation of any federal (including the Uniform Code of Military Justice), state foreign country, which is a misdemeanor, gross misdemeanor, felony, violation Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor tr control of a motor vehicle while under the influence of a chemical substance, incluminor traffic offense), or for any offense which is related to the manufacture, distrit of controlled substances? *Please note that you MUST disclose ANY investigation the final disposition was dismissal, or expungement during this time period.	e or local of the U affic offe ading alco bution, p	law, or the Iniform Code nse (driving phol, is not corescribing, or	aws of any e of Military or being in onsidered a dispensing
7.	Have you been denied a license or certification/registration to provide respirator practice as a respiratory care therapist or permission to take an examination therapist or permission to practice any other healing art in any state, country or like the state of the	o practic	e as a respi	
8.	Have you had a certificate or license to provide respiratory care services or suspended, limited, or restricted in any state, country or U.S. territory?	any oth		
9.	Have you voluntarily surrendered a license or certificate to provide respiratory care in any state, country or U.S. territory in lieu of disciplinary action?		s or any othe Yes	r healing art No
10.	Have you had your registration/certification revoked, suspended and/or limited by Care?	the Natio	onal Board of Yes	Respiratory No
11.	Have you been denied membership, been asked to resign or expelled from a medical organization?	lical soci		rofessional

_Yes

No

investigated for; d) charged with; or e) convicted of	gation; b) notified that you were under investigation for; c) any violation of a statute, rule or regulation governing your dical licensing board, hospital, medical society, governmental of Medical Examiners?
13. Have you actively practiced respiratory care in Neva	da within the past 24 months?YesNo
ATTESTATION	ns / Affirmations
CHILD SUPPORT STATEMENT	
PLEASE PLACE AN "X" NEXT TO THE STATEMENT	THAT APPLIES TO YOU:
I am not subject to a court order for the suppo	ort of a child;
	of one or more children and am in compliance with the d by the district attorney or other public agency enforcing ed pursuant to the order; OR
	one or more children and am NOT in compliance with orney or other public agency enforcing the order for the e order.
ATTESTATION REGARDING THE REPORTING O	OF THE ABUSE OR NEGLECT OF A CHILD
I attest and affirm that I am aware of and understand t 432B.220 regarding the abuse or neglect of a child.	he reporting requirements found in Nevada Revised StatuteYesNo
http://www.leg.state.nv.us/NRS	/NRS-432B.html#NRS432BSec220
MILITARY SERVICE ATTESTATION	
1-Have you ever served in the United States Military (to If your answer is "No," you do not have to complete the remain Attestation.	
2-If yes, which branch of service did you serve?	 ☐ Air Force ☐ Army ☐ Navy ☐ Marine Corps ☐ Coast Guard
3-Military occupation specialty or specialties?	□ Administration or Personnel □ Logistics or Supply □ Aviation □ Maintenance □ Civil Engineering □ Medical Services □ Communications □ Security Forces or Military Police □ Infantry or Armor □ Other □ Legal or Chaplin Corps
4&5-Dates of service in the Military: 4-From: DD	// 5-To://
6-Are you still serving?	
7-Have you ever served on active duty in the Armed For	ces of the United States?No
8-Have you ever been assigned to duty for a minimum component of the Armed Forces of the United States?	n of 6 continuous years in the National Guard or a reserve
	e United States Public Health Service or the Commissioned tration of the United States in the capacity of a commissioned es? YesNo
10-If your answer to question(s) 7, 8 and/or 9 is "Yes," didishonorable? (Unless you were dishonorably discharged, your a	d you separate from such service under conditions other than answer should be "Yes.") YesNo

BUSINESS LICENSE ATTESTATION
Do you have a business license issued by the Nevada Secretary of State in your individual name?
If yes, provide the business license number:
COMMUNICATIONS AFFIRMATION
I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.
Printed Name of Licensee:
Signature of Licensee:
Electronic Mail Address:
CENTURY
CERTIFICATION
I am currently certified by the National Board for Respiratory Care (NBRC). Note: You do not have to be a member of the NBRC but you are required to be currently certified in order to maintain licensure in the State of Nevada.
YesNo
<u>ATTACH COPY</u> OF PROOF OF YOUR CURRENT CERTIFICATION. (YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL <u>NOT</u> BE RETURNED TO YOU.)
CONTINUING EDUCATION
ALL CONTINUING EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2017 THROUGH JULY 1, 2019. Please place a check mark next to the statement that applies to you.
I was initially licensed in Nevada prior to or during the first six months of the biennial period of registration (July 1, 2017 - December 31, 2017) and have completed a minimum of twenty (20) hours of continuing professional education, twelve (12) of which must be related to respiratory care and two (2) hours of which must be in the subject matter of ethics.
I was initially licensed in Nevada during the second six months of the biennial period of registration (January 1, 2018 – June 30, 2018) and have completed a minimum of fifteen (15) hours of continuing professional education, nine (9) of which must be related to respiratory care and two (2) hours of which must be in the subject matter of ethics.
I was initially licensed in Nevada during the third six months of the biennial period of registration (July 1, 2018 - December 31, 2018) and have completed a minimum of ten (10) hours of continuing professional education, six (6) of which must be related to respiratory care and two (2) hours of which must be in the subject matter of ethics.
I was initially licensed in Nevada during the fourth six months of the biennial period of registration (January 1, 2019 – July 1, 2019) and have completed a minimum of five (5) hours of continuing professional education, three (3) of which must be related to respiratory care and two (2) hours of which must be in the subject matter of ethics.
FOR A CURRENT LIST OF APPROVED CONTINUING PROFESSIONAL EDUCATION SOURCES, YOU MAY VISIT THE BOARD'S WEBSITE AT www.medboard.nv.gov and click the "continuing Education requirements for Practitioner of Respiratory Care" Link.
RENEWAL APPLICATION AFFIRMATION
BY SIGNING BELOW, I SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:

Nevada State Board of Medical Examiners

9600 Gateway Drive

Reno, NV 89521

or fax to:

775-688-2321

<u>Please type or print legibly</u> .				
Name of Licensee:				
Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express	☐ Discover			
Name on Credit Card:				
Business Name (if applicable):				
Credit Card Billing Address:				
Phone Number:				
Credit Card Number:				
Expiration Date: / Credit Card Verification Code: (MM) (YYYY) (Three or four digit code found on	credit card)			
For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.				
I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time				
payment in the amount of \$, and an additional 2% s	ervice fee.			
Printed Name:				
Authorized Signature:	Date:			