

**Applicant:** Each school where respiratory care education was received must complete this form. If more than one school, photocopies of this blank form may be made and used. Transcripts must also be submitted by the school(s).

**FORM 1**

**PRACTITIONER OF RESPIRATORY CARE  
EDUCATION VERIFICATION**

This certifies that \_\_\_\_\_  
Printed Name of Applicant Date of Birth

was enrolled in \_\_\_\_\_  
Name of Respiratory Care School (Location – City / State / Country)

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**The following information to be completed by program only.**

The undersigned further certifies that the records of this institution show that the applicant attended this respiratory care program from *(please only include dates related to the respiratory care program/degree)*

from: \_\_\_\_\_ to: \_\_\_\_\_  
Dates of attendance – (month/year) Dates of attendance – (month / year)

**The applicant successfully received their respiratory care practitioner degree on**

the \_\_\_\_\_ day of \_\_\_\_\_.  
(date) (month) (year)

Signed and the institutional seal affixed this \_\_\_\_\_ day of \_\_\_\_\_, 2 \_\_\_\_\_

By: \_\_\_\_\_  
Printed name of President, Registrar or Dean)

Title \_\_\_\_\_  
Title of President, Registrar or Dean

Signature \_\_\_\_\_  
*Signature of President, Registrar or Dean \*\**

Affix Seal Here

Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

\*\* Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

**Completed form is to be mailed by the verifying institution directly to:**

**Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521**

**Practitioner of Respiratory Care School :** If you have questions, you may contact the Board at (775) 688-2559. The Board requires that this verification form be received by mail or email **only**, and NOT by facsimile. **Emails may be sent to nsbme@medboard.nv.gov**