

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)

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 institution

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

The applicant successfully completed their respiratory care practitioner training program 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 and NOT by facsimile.