

NEVADA STATE BOARD OF MEDICAL EXAMINERS

PRACTITIONER OF RESPIRATORY CARE MEDICAL LICENSURE FOR APPLICANTS THAT ARE AN ACTIVE MEMBER OF, OR THE SPOUSE OF AN ACTIVE MEMBER OF, THE ARMED FORCES OF THE UNITED STATES, A VETERAN OR THE SURVIVING SPOUSE OF A VETERAN

Specific eligibility requirements outside of traditional application requirements are as follows:

- Is an active member of, or the spouse of an active member of, the U.S. Armed Forces, a veteran or surviving spouse of a veteran
- For veterans/surviving spouses of veterans – the veteran was honorably discharged
- Holds valid, unrestricted license in another U.S. state or the District of Columbia
- Is currently NBRC certified
- Has not been disciplined and is not currently under investigation by any state Board
- Has not had a malpractice payout

Applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½” x 11” in size. Your application is a public document.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Fees applicable if licensed between July 1, 2023 – June 30, 2024:

Application Fee	Registration Fee	Criminal Background Investigation Fee		
\$50	\$200	\$75	=	\$325

Fees applicable if licensed between July 1, 2024 – June 30, 2025:

Application Fee	Registration Fee	Criminal Background Investigation Fee		
\$50	\$100.00	\$75	=	\$225.00

The Application fee and Criminal Background Investigation fee will not be refunded. You may pay by cashier’s check or money order, payable to “NEVADA STATE BOARD OF MEDICAL EXAMINERS,” or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

PLEASE NOTE:

The “practice of respiratory care” includes:

1. Therapeutic and diagnostic use of medical gases, humidity and aerosols and the maintenance of associated apparatus;
2. The administration of drugs and medications to the cardiopulmonary system;
3. The provision of ventilatory assistance and control;
4. Postural drainage and percussion, breathing exercises and other respiratory rehabilitation procedures;
5. Cardiopulmonary resuscitation and maintenance of natural airways and the insertion and maintenance of artificial airways;
6. Carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practitioner of nursing relating to respiratory care;
7. Techniques for testing to assist in diagnosis, monitoring, treatment and research related to respiratory care, including the measurement of ventilatory volumes, pressures and flows, collection of blood and other specimens, testing of pulmonary functions and hemodynamic and other related physiological monitoring of the cardiopulmonary system; and
8. Training relating to the practice of respiratory care.

The Board’s staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be

scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the National Board for Respiratory Care, Inc., or its successor organization.

NRS 630.277 Requirements; prohibitions; intern in respiratory care.

1. Every person who wishes to practice respiratory care in this State must:

(a) Have:

- (1) A high school diploma; or
- (2) A general equivalency diploma or an equivalent document;

(b) Complete an educational program for respiratory care which has been approved by the Commission on Accreditation of Allied Health Education Programs or its successor organization or the Commission on Accreditation for Respiratory Care or its successor organization;

(c) Pass the examination as an entry-level or advanced practitioner of respiratory care administered by the National Board for Respiratory Care or its successor organization;

(d) Be certified by the National Board for Respiratory Care or its successor organization; and

(e) Be licensed to practice respiratory care by the Board and have paid the required fee for licensure.

2. Except as otherwise provided in subsection 3, a person shall not:

(a) Practice respiratory care; or

(b) Hold himself or herself out as qualified to practice respiratory care,

↪ in this State without complying with the provisions of subsection 1.

3. Any person who has completed the educational requirements set forth in paragraphs (a) and (b) of subsection 1 may practice respiratory care pursuant to a program of practical training as an intern in respiratory care for not more than 12 months after completing those educational requirements.

(Added to NRS by 2001, 759; A 2009, 2959; 2011, 2860; 2013, 3293; 2015, 492)

NAC 630.500 Qualifications of applicants. (NRS 630.130, 630.279) An applicant for licensure as a practitioner of respiratory care must have the following qualifications:

1. If he or she has not practiced as a practitioner of respiratory care for 12 months or more immediately preceding his or her application for licensure in this State, the applicant must, except as otherwise provided in subsections 2 and 3, at the order of the Board, take and pass any examination that the Board deems appropriate to test the professional competency of the practitioner.

2. If he or she has not practiced as a practitioner of respiratory care for 12 months or more but less than 5 years immediately preceding his or her application for licensure in this State, the applicant may provide proof that he or she has successfully completed 10 units of continuing education for each year or portion thereof he or she has not practiced respiratory care. If he or she provides proof of successfully completing at least 10 units of continuing education for each year or portion thereof he or she has not practiced respiratory care, the applicant is exempt from the examination required pursuant to subsection 1.

3. If he or she has not practiced as a practitioner of respiratory care for 5 years or more immediately preceding his or her application for licensure in this State, the applicant must retake and pass the examination required to be certified as a practitioner of respiratory care administered by the National Board for Respiratory Care or its successor organization.

4. Be a citizen of the United States or be lawfully entitled to remain and work in the United States.

5. Be able to communicate adequately orally and in writing in the English language.

6. Be of good moral character and reputation.

7. Be in compliance with the provisions of NRS 630.277.

(Added to NAC by Bd. of Medical Exam'rs by R108-01, eff. 11-29-2001; A by R176-08, 2-11-2009; R036-13, 2-26-2014)

NAC 630.505 Application for license. (NRS 630.130, 630.279)

1. An application for licensure as a practitioner of respiratory care must be made on a form supplied by the Board. The application must include:

(a) The date of birth and the birthplace of the applicant, his or her sex and the various places of his or her residence after reaching 18 years of age;

(b) The education of the applicant, including, without limitation, all high schools, postsecondary institutions and professional institutions attended, the length of time in attendance at each high school or institution and whether he or she is a graduate of those schools and institutions;

(c) Whether the applicant has ever applied for a license or certificate as a practitioner of respiratory care in another state and, if so, when and where and the results of his or her application;

(d) The professional training and experience of the applicant;

(e) Whether the applicant has ever been investigated for misconduct as a practitioner of respiratory care or had a license or certificate as a practitioner of respiratory care revoked, modified, limited or suspended or whether any disciplinary action or proceedings have ever been instituted against him or her by a licensing body in any jurisdiction;

(f) Whether the applicant has ever been convicted of a felony or an offense involving moral turpitude;

(g) Whether the applicant has ever been investigated for, charged with or convicted of the use, illegal sale or distribution of controlled substances; and

(h) A public address where the applicant may be contacted by the Board.

2. An applicant must submit to the Board:

(a) Proof of completion of an educational program as a practitioner of respiratory care that is approved by the Commission on Accreditation of Allied Health Education Programs or its successor organization or the Commission on Accreditation for Respiratory Care or its successor organization;

(b) Proof of passage of the examinations required by NRS 630.277 and NAC 630.500 and 630.515; and

(c) Such further evidence and other documents or proof of qualifications as required by the Board.

3. Each application must be signed by the applicant and sworn to before a notary public or other officer authorized to administer oaths.

4. The application must be accompanied by the applicable fees for the application for licensure and biennial registration.

5. An applicant shall pay the reasonable costs of any examination required for licensure.

(Added to NAC by Bd. of Medical Exam'rs by R108-01, eff. 11-29-2001; A by R043-11, 5-30-2012; R023-15, 12-30-2015)

NAC 630.540 Grounds for discipline or denial of licensure. (NRS 630.130, 630.279) A practitioner of respiratory care is subject to discipline or denial of licensure by the Board if, after notice and hearing in accordance with this chapter, the Board finds that the practitioner of respiratory care:

1. Willfully and intentionally made a false or fraudulent statement or submitted a forged or false document in applying for a license or renewing a license.

2. Performed respiratory care services other than as permitted by law.

3. Committed malpractice in the performance of respiratory care services, which may be evidenced by claims settled against a practitioner of respiratory care.

4. Disobeyed any order of the Board or an investigative committee of the Board or violated a provision of this chapter.

5. Is not competent to provide respiratory care services.

6. Lost his or her certification by the National Board for Respiratory Care or its successor organization.

7. Failed to notify the Board of loss of certification by the National Board for Respiratory Care or its successor organization.

8. Falsified records of health care.

9. Rendered respiratory care to a patient while under the influence of alcohol or any controlled substance or in any impaired mental or physical condition.

10. Practiced respiratory care after his or her license has expired or been suspended.

11. Has been convicted of a felony, any offense involving moral turpitude or any offense relating to the practice of respiratory care or the ability to practice respiratory care.

12. Has had a license to practice respiratory care revoked, suspended, modified or limited by any other jurisdiction or has surrendered such license or discontinued the practice of respiratory care while under investigation by any licensing authority, a medical facility, a branch of the Armed Forces of the United States, an insurance company, an agency of the Federal Government or any employer.

13. Engaged in any sexual activity with a patient who is currently being treated by the practitioner of respiratory care.

14. Engaged in disruptive behavior with physicians, hospital personnel, patients, members of the family of a patient or any other person if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.

15. Engaged in conduct that violates the trust of a patient and exploits the relationship between the practitioner of respiratory care and the patient for financial or other personal gain.

16. Engaged in conduct which brings the respiratory care profession into disrepute, including, without limitation, conduct which violates any provision of a national code of ethics adopted by the Board by regulation.

17. Engaged in sexual contact with a surrogate of a patient or other key person related to a patient, including, without limitation, a spouse, parent or legal guardian, that exploits the relationship between the practitioner of respiratory care and the patient in a sexual manner.

18. Made or filed a report that the practitioner of respiratory care knows to be false, failed to file a record or report as required by law or willfully obstructed or induced another to obstruct such filing.

19. Altered the medical records of a patient.

20. Failed to report any person that the practitioner of respiratory care knows, or has reason to know, is in violation of the provisions of chapter 630 of NRS or NAC 630.500 to 630.560, inclusive, relating to the practice of respiratory care.

21. Has been convicted of a violation of any federal or state law regulating the prescription, possession, distribution or use of a controlled substance.

22. Held himself or herself out or permitted another to represent him or her as a licensed physician.

23. Violated any provision that would subject a practitioner of medicine to discipline pursuant to NRS 630.301 to 630.3065, inclusive, or NAC 630.230.

(Added to NAC by Bd. of Medical Exam'rs by R108-01, eff. 11-29-2001)

FAQ for Practitioners of Respiratory Care

Grounds for rejection of an application for practitioner of respiratory care licensure:

If it appears that:

1. An applicant for licensure as a practitioner of respiratory care is not qualified or is not of good moral character or reputation;
2. Any credential submitted is false; or
3. The application is not made in proper form or other deficiencies appear in it, the application may be rejected.

Educational Requirements for Respiratory Therapists

Every person who wishes to practice respiratory care in this State must:

(a) Have:

- (1) A high school diploma; or
- (2) A general equivalency diploma or an equivalent document;

(b) Complete an educational program for respiratory care which has been approved by the Commission on Accreditation of Allied Health Education Programs or its successor organization or the Committee on Accreditation for Respiratory Care or its successor organization;

Temporary License otherwise known as Practitioner of Respiratory Care Intern

Any person who has completed the required educational requirements may be licensed as an Intern and practice respiratory care pursuant to a program of practical training as an intern in respiratory care for not more than 12 months after completing those educational requirements and prior to passing the NBRC examination.

Communication

The practitioner of respiratory care applicant must be able to communicate adequately, both orally and in writing, in the English language. The practitioner of respiratory care applicant must be of good moral character and reputation.

National Board for Respiratory Care (NBRC)

If a licensee loses certification by the National Board for Respiratory Care, Inc., or its successor organization, his or her license to practice respiratory care in Nevada is automatically suspended until further order of the Board.

Termination of Employment

The practitioner of respiratory care shall immediately notify the Board of termination of employment as a practitioner of respiratory care. The practitioner of respiratory care shall submit to the Board a summary of the reasons for and circumstances of the termination of employment.

**PRACTITIONER OF RESPIRATORY CARE
APPLICATION CHECKLIST
TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT**

	a.	<p>APPLICATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Properly completed, signed and notarized application, including Applicant Responsibility statement; <input type="checkbox"/> Recent passport quality photograph (at least 2"x 2") <input type="checkbox"/> Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 13, 14, 20, 21, 22, 23, 24, and 25; <input type="checkbox"/> Release form - signed and notarized (Form A); <input type="checkbox"/> Form C – Practitioner of Respiratory Care Military Endorsement Form – signed and notarized <input type="checkbox"/> Copy of current military orders or DD-214
	b.	<p>FEES:</p> <ul style="list-style-type: none"> • Proper application, registration, AND criminal background investigation fees – cashier’s check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. Note: Application and criminal background investigation fees are <u>non-refundable</u>;
	c.	<p>IDENTITY (Important identity documents will be returned to you via secured mail):</p> <ul style="list-style-type: none"> • U.S. born citizens – Photocopy of U.S. Birth Certificate or current (unexpired) U.S. passport <u>with notarized</u> Certificate of Identification • Foreign-born citizens – Photocopy of current (unexpired) U.S. passport or Certificate of Naturalization <u>with notarized</u> Certificate of Identification • Non U.S. citizens – Copy of both sides of Alien Registration card, Employment Authorization card, or Visa <u>and</u> copy of foreign passport;
	d.	<p>EDUCATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Copy of high school transcripts, diploma, or general equivalency diploma showing graduation date; <input type="checkbox"/> Copy of transcripts or diplomas for degrees other than Respiratory Care degree – Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board’s website;
	e.	<p>FINGERPRINTING:</p> <ul style="list-style-type: none"> • Once the application and criminal background investigation fee have been received, a fingerprint card and instructions will be mailed to you. The fingerprint card you receive from the Board contains the necessary account numbers required for processing. The completed card <u>must</u> be returned to the Board as well as the signed Civil Applicant Waiver (included in your application package) prior to licensure. Note: Receipt of the Criminal history background results will not delay licensure.

**DIRECT SOURCE VERIFICATIONS
TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN
BY THE VERIFYING INSTITUTION TO BOARD OFFICE**

Verifying agencies may charge a fee. Do not provide pre-stamped or pre-addressed envelopes.

	a.	<p>PRACTITIONER OF RESPIRATORY CARE SCHOOL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Verification of completion of Practitioner of Respiratory Care Education (Form 1) to be completed by your Respiratory Therapy school; <input type="checkbox"/> Official transcripts from Practitioner of Respiratory Care school;
	b.	<p>EXAMINATION:</p> <ul style="list-style-type: none"> • Current certification by the National Board for Respiratory Care, Inc. (Form 2), or its successor organization (applicant may request this verification online: www.nbrc.org);

APPLICATION GUIDE

Identity - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name (i.e., U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change).

Malpractice - If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed, including copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s).

Investigation - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a respiratory therapist, you should answer affirmatively to question #25 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

Arrest - If you have ever been arrested, read question #13 carefully. You will be expected to provide a signed and dated explanation addressed to the Nevada State Board of Medical Examiners for any arrest(s) no matter how long ago it may have occurred, whether it was expunged or not. Provide a copy of the arrest report, proof of completion of probation and/or time served, community service, fines paid and any other documentation applicable to the incident(s).

Release for Communication with a Person other than the Applicant: If you wish to authorize the Board to communicate about the status of your application for licensure with someone other than yourself, provide a brief signed written release of authorization indicating the specific name of the person thus providing the Board with authority to tender information related to your application status.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

**ATTENTION APPLICANT!
RESPONSIBILITY STATEMENT**

**Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521**

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during your training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

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I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

Nevada Department of **Public Safety**

CIVIL APPLICANT WAIVER

NOTICE OF NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is subject pursuant to NRS 630.167, and who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

1. You must be notified by Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.
2. Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.
3. Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.
4. Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.
5. If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record. The procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at, 28 CFR 16.34 provides for the proper procedure to do so.

Applicants Initials: _____ Date: _____

6. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record,

you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <https://www.fbi.gov/services/cjis/identity-history-summary-checks> and <https://www.edo.cjis.gov> .

7. If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via <https://www.edo.cjis.gov> . The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)
8. You have the right to expect that officials receiving the results of the fingerprint-based criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal or state statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.
9. I hereby authorize Nevada State Board of Medical Examiners to submit a set of my fingerprints to the Nevada Department Public Safety, Records Bureau for the purpose of accessing and reviewing State of Nevada and FBI criminal history records that may pertain to me.
10. I hereby release from liability and promise to hold harmless under any and all causes of legal action, the State of Nevada, its officer(s), agent(s) and/or employee(s) who conducted my criminal history records search and provided information to the submitting agency for any statement(s), omission(s), or infringement(s) upon my current legal rights. I further release and promise to hold harmless and covenant not to sue any persons, firms, institutions or agencies providing such information to the State of Nevada on the basis of their disclosures. I have signed this release voluntarily and of my own free will.

A reproduction of this authorization for release of information by photocopy, facsimile or similar process, shall for all purposes be as valid as the original. In consideration for processing my application I, the undersigned, whose name and signature voluntarily appears below; do hereby and irrevocably agree to the above.

Applicant's Name:
PLEASE PRINT

Last Name	First Name	Middle

Applicant's Signature: _____
Date: _____

Agency Account #: 881183

Agency Representative:
PLEASE PRINT

Linn	Kory

Agency Representative Signature: *K. Linn, Chief of Licensing*
Date: 1.30.23

**PRACTITIONER OF RESPIRATORY CARE
MILITARY ENDORSEMENT
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS**

9600 Gateway Drive, Reno, NV 89521
Phone (775) 688-2559

Date Received by Board

License No. _____

File No. _____

For Board Use Only

Identity:

1. Present Legal Name _____
Last First Middle Maiden

List any other name ever used _____

1(a) I am an active member of the Armed Forces _____ I am a veteran _____ I am the spouse of an active member _____ I am the surviving spouse of a veteran of the Armed Forces of the United States _____.

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.

The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address _____
Street City County State Zip

Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers (_____) _____ (_____) _____ (_____) _____ (_____) _____
Office Fax Home Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____ Gender ___ F ___ M
Month / Day / Year (City / State / Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____ Visa _____

7. Social Security Number _____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice as a practitioner of respiratory care shall include the social security number of the applicant in the application submitted to the Board.

NAC 630.505(2)(c) The applicant must submit to the Board such further evidence and other documents or proof of qualifications as required by the Board.

Questions:

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

"Medical condition" 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.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR LICENSURE FORM.

8. Do you currently have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____ Yes _____ No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice as a respiratory therapist, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation?
(If "Yes," attach explanation on separate sheet.) _____ Yes _____ No _____ N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety?
(If "Yes," attach explanation on separate sheet.) _____ Yes _____ No _____ N/A

Malpractice Questions:

11. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____ Yes _____ No
(If "Yes," attach explanation on separate sheet.)
12. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? _____ Yes _____ No
(If "Yes," attach explanation on separate sheet.)
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Arrest Question:

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. _____ Yes _____ No
(If "Yes," attach explanation on separate sheet.)
-
-

Nevada License History:

14. Have you previously applied for an allied health license in Nevada? (This does not include Blood Gas Licenses). _____ Yes _____ No
(If "Yes," attach explanation on separate sheet.)
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Practitioner for Respiratory Care Education:

15. List all schools attended in **chronological order** including high school, college and/or university, **and** Practitioner of Respiratory care education. Please show dates of attendance in months and years:

School Name	City/State	Type of Degree / Major Received	Dates of Attendance From (mo/yr) To (mo/yr)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Respiratory Degree granted by:

Respiratory School	City / State	<u>Exact</u> Date of Issuance

Activities:

17. List briefly all activities in **chronological order** all activities for the five (5) years preceding your application submission date. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR. Activities include working as a Respiratory Therapist and also non-medical activities (seeking employment, moving, job search, applying for a license, vacation etc.)

Activities	City / State (and Country if other than U.S.)	From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet)

State licenses:

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as a respiratory therapist in any state or territory.

State/Territory	License #	Date of Issuance (Mo/Yr)	Status
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(All information must begin on the application. If more space is needed, please attach separate sheet)

Examination:

19. Are you currently certified by and/or registered with the National Board for Respiratory Care? Yes No

If "No", Date scheduled to sit for the exam: _____

Expiration Date: _____

(For those who are certified or registered after

7/1/2002)

If you are an RRT, provide Registration number: _____

Disciplinary Questions:

20. Have you ever been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) Yes No

21. Have you ever had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) Yes No

22. Have you ever voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) Yes No

23. Have you ever failed the National Board for Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration? If your answer is "yes", give details regarding how many times you failed, including dates and the reason(s) you believe you failed the examination(s). Sign your explanation. (If "Yes," attach explanation on separate sheet.) Yes No

24. Have you ever had your registration/certification revoked, suspended and/or limited by the National Board for Respiratory Care? (If "Yes," attach explanation on separate sheet.) Yes No

25. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) Yes No

Attestations/Affirmations:**CHILD SUPPORT STATEMENT**

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

(a) I am not subject to a court order for the support of a child;

(b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order;

(c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____ Yes _____ No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____ Yes _____ No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve? Air Force
 Army
 Navy
 Marine Corp
 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: ____/____/____ 5-To: ____/____/____
DD MM YYYY DD MM YYYY

6-Are you still serving? _____ Yes _____ No

7-Have you ever served on active duty in the Armed Forces of the United States? _____ Yes _____ No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____ Yes _____ No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____ Yes _____ No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.") _____ Yes _____ No _____ N/A

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX (6) MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

CENTER AND ATTACH PHOTOGRAPH HERE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six (6) months.

Signature of applicant Date

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant

Date

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of

_____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

END OF APPLICATION

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing board any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

A photocopy of this form will serve as an original (Board use only).

Please return completed form to:

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

REQUEST FOR LICENSURE BY ENDORSEMENT VIA NAC 630.513

(as amended by R009-19 New Provision #2)

State your Name, and fill in the state, territory, or District of Columbia in which licensed:

I, _____, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously, licensed to practice respiratory care by the licensing agency of

_____, since _____.
(state, territory, or District of Columbia) (month / day / year)

That I have never had a license to practice respiratory care in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence. That I am an active member of, or the spouse of an active member of, the Armed Forces of the United States, a veteran, or the surviving spouse of a veteran. I have not been disciplined and am not currently under investigation by the corresponding regulatory authority of the District of Columbia or any state or territory in which I hold a license to practice as a practitioner of respiratory care. I am currently certified by the National Board for Respiratory Care and I have not been held civilly or criminally liable for malpractice in the District of Columbia or any state or territory of the United States.

That I am the person named in the license to practice respiratory care in _____,
(State, territory, or District of Columbia)

and that said license to practice respiratory care was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by Endorsement, and any accompanying materials, are complete and correct.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

(NOTARY SEAL)

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

Please return completed form to:

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

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).

**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 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 and NOT by facsimile.

Applicant: This form is to be mailed to the National Board for Respiratory Care (NBRC) for completion along with your check for the appropriate fee. The website for the NBRC is <https://www.nbrc.org/> if you have questions.

FORM 2

The National Board for Respiratory Care, Inc.
10801 Mastin Street, Ste. 300
Overland Park, Kansas 66010
(913) 895-4900
Fax: 913-712-9283

Part 1 - to be completed by applicant

Printed name of applicant: _____
And/or social security number: _____

I am in the process of applying for practitioner of respiratory care licensure in the state of Nevada. I hereby authorize release of the information, requested in Part 2 below, directly to the Nevada State Board of Medical Examiners.

Signature of applicant: _____

*You must include check or money order in the amount of \$5.00 made payable to the NBRC. (If you are not an active member, the fee is \$5.00.)

.....

Part 2 - to be completed by The National Board for Respiratory Care, Inc. and RETURNED DIRECTLY TO THE OFFICE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS (Applicant may request this verification online: www.nbrc.org (under the 'Credentialed Practitioners' link))

I certify that _____
(Name of applicant)

was granted initial certification/registration by The National Board for Respiratory Care, Inc. on:

Date issued: _____

Certificate/Registration Number: _____

The above-referenced certificate/registration is: _____ Current, in good standing
_____ Not current

Expiration date of current certification/registration: _____

Signature and title of certifying individual: _____

(date)

Completed form is to be returned by The National Board for Respiratory Care, Inc. directly to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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

Please type or print legibly.

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: _____ / _____
(MM) (YYYY)

Credit Card Verification Code: _____
(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 2.5% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____

Email Address for receipt: _____

Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.