



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 741-3807 OR 1-800-778-4123 ext 741-3807
www.tn.gov/health

**APPLICATION INSTRUCTIONS FOR LICENSURE AS REGISTERED RESPIRATORY THERAPIST (RRT) OR
CERTIFIED RESPIRATORY THERAPIST (CRT OR CRTT)
LICENSURE APPLICATION CHECK SHEET**

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

- | | Done |
|--|-------|
| 1. Complete, sign, have notarized and mail the application pages 1 through 6. | _____ |
| 2. Complete and mail Attachment 1 along with a check or money order to the National Board of Respiratory Care. | _____ |
| 3. Complete and mail Attachment 2 to each state, county, or province in which you hold, or have ever held, a license to practice any profession. | _____ |
| 4. Complete and mail Attachment 3 to the school at which you completed your respiratory care educational/training program. | _____ |
| 5. Attach to the application a clear, recognizable, full faced passport style photograph of yourself.(sized between 2x2 & 4x4) Computer generated images are not acceptable. | _____ |
| 6. Submit with the application, a check or money order in U.S. funds in the amount of \$160.00, which includes an application fee of \$70.00, license fee of \$80.00 and a \$10.00 state regulatory fee made payable to the State of Tennessee. (If applying for an upgrade as listed in #7, this fee is not applicable.) | _____ |
| 7. If licensed in the state of Tennessee as a certified Respiratory Therapist (CRT or CRTT) and wish to upgrade to a Registered Respiratory Therapist (RRT), submit with the application a check or money order in U.S. funds in the amount of \$30.00, which includes a \$20.00 upgrade fee and a \$10.00 state regulatory fee, made payable to the State of Tennessee. | _____ |
| 8. Complete and return the Mandatory Practitioner Profile. This must be completed before licensure can be considered. The obtain a Mandatory Practitioner Profile and instructions go to click here. | _____ |
| 9. Criminal Background Check. To obtain instructions for a criminal background check click here. | _____ |
| 10. All applicants must complete the Declaration of Citizenship Attachment 4. | _____ |

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. All application fees are non-refundable.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institution in this application process, must be mailed directly to:

**Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243**

**For Federal Express or Special Courier:
Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37228**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
4. **We will discuss application status with the applicant or applicant's spouse only.** Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.
5. If all necessary documentation has not been received when your application is received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.
6. **Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.**
7. It is recommended that you do not make arrangements to accept employment as a Respiratory Care Practitioner in Tennessee until you are granted a license, temporary permit or temporary license by the Board of Respiratory Care.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have either a Tennessee License or a Board issued authorization in your possession before you may lawfully practice as either a Registered or Certified Therapist.

ATTACH A
CURRENT PASSPORT
STYLE PHOTOGRAPH



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2nd FLOOR
NASHVILLE, TN 37243

RRT	3747 – 001	\$ 70.00
	3747 – 001	\$ 80.00
	3747 – 006	\$ 10.00
		\$ 160.00
CRT	3750 – 001	\$ 70.00
	3750 – 001	\$ 80.00
	3750 – 006	\$ 10.00
		\$ 160.00
Upgrade	3747 – 001	\$ 20.00
	3747 – 006	\$ 10.00
		\$ 30.00

BOARD OF RESPIRATORY CARE
(615) 741-3807 or Toll Free 1-800-778-4123 ext 741-3807
LICENSURE APPLICATION

Choose the appropriate certificate category and any endorsements for which you qualify within the category. See the Practice Act and the Rules and Regulations to determine the requirements for each category of practitioner.

LICENSURE ALTERNATIVES

LICENSURE REQUEST	For Office Use Only	
A. _____ Upgrade from Certified Therapist to Registered Therapist	_____	_____
B. _____ Temporary License	_____	License Qualified
_____ Registered Therapist	_____	Temporary License Qualified
_____ Certified Therapist	_____	Temporary Authorization
	_____	ABG Endorsement Qualified
C. _____ Registered Therapist	_____	License Qualified
_____ By Examination	_____	Temporary License Qualified
_____ By Reciprocity	_____	Temporary Authorization
	_____	ABG Endorsement Qualified
D. _____ Certified Therapist	_____	License Qualified
_____ By Examination	_____	Temporary License Qualified
_____ By Reciprocity	_____	Temporary Authorization
	_____	ABG Endorsement Qualified

PERSONAL INFORMATION

Name _____

Last First Middle Maiden

Social Security Number: _____ - _____ - _____ Date of Birth: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

Mailing Address: _____ County (TN Applicants Only): _____

_____ Home Phone #: _____

_____ Work Phone #: _____

Home E-Mail Address: _____

Do you wish to receive notification, including renewal notification from the Department of Health via email? YES NO

Place of Birth: _____ Sex (for statistical purposes only) Female ____ Male ____

U.S. Citizen: ____ Yes or ____ No (All applicants must complete the Declaration of Citizenship attachment.)

EDUCATIONAL AND EMPLOYMENT INFORMATION

List the education you graduated from for your respiratory care training. Please provide the following information for all educational institutions you have attended.

From: _____ To: _____
 Mo/Yr Mo/Yr Educational Institution/Respiratory Care City State

From: _____ To: _____
 Mo/Yr Mo/Yr Educational Institution/Respiratory Care City State

Please complete your entire Respiratory Care employment history starting with the most current position first. Use the back of this page if you need additional space. Explain any gaps in employment.

<u>DATES</u>	<u>LOCATION</u>	<u>EMPLOYER, POSITION, AND DUTIES</u>
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties
From: _____ To: _____ Mo/Yr Mo/Yr	_____ (City) (State)	_____ Employer _____ Position _____ Duties

LICENSURE INFORMATION

List below **ALL STATES, COUNTRIES OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED OR CERTIFIED** as a Respiratory Care Practitioner. Submit a copy of **Attachment #2** to all such States, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification or permit as a health professional other than a Respiratory Care Practitioner. Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- | | Yes | No |
|---|-------|-------|
| 1. Are you certified (CRT or CRTT) by the National Board for Respiratory Care?
If so, complete Attachment #1 and send it to the NBRC. | _____ | _____ |
| 2. Are you registered (RRT) by the National Board for Respiratory Care?
If so, complete Attachment #1 and send it to the NBRC. | _____ | _____ |
| 3. Have you ever applied for a Respiratory Care license or certificate in Tennessee? () Assistant () Certified Therapist () Registered Therapist | _____ | _____ |
| 4. Have you ever received a Respiratory Care temporary permit, certificate, or license in Tennessee. | _____ | _____ |

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to any questions in this part are in the affirmative, attach an explanation on a separate sheet. *In support of your explanation, the final documents or orders from the issuing states, or agencies must be submitted along with this application.*

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

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis (if necessary) and exercise reasoned judgments and to learn and keep abreast of developments in your profession; and
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers, and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medication, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety.	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice.	_____	_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.]

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn
(Applicant's Name) (City) (State)

and identified as the person referred to in this application, attests to the truth of each statement made in said application, I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of respiratory care in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board or Board interview;

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice respiratory care;

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification;

ACKNOWLEDGE that I, as an applicant for certification or licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me, this _____ day of _____, 20_____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243

NBRC VERIFICATION

If you are certified or registered by the NBRC, please complete the top portion of this form and mail it to the address below. You must include a check or money order for \$5.00 made payable to the NBRC. (If you are not an active member of the NBRC, the charge is \$20.00).

Send to:

**The National Board of Respiratory Care, Inc.
18000 W. 105th Street
Olathe, Kansas 66061
913-895-4900**

To Be Completed By Applicant (Please Print In Ink)

Dear NBRC Official:

I am applying for a License to practice respiratory care in the State of Tennessee. The State Board of Respiratory Care requires that a credential letter be forwarded directly to their office by the NBRC.

Applicant's Name _____
(First) (M.I.) (Last)

Social Security No. _____ - _____ - _____

To Be Completed by NBRC

Name applicant credentialed by if different from above:

(First) (M.I.) (Last)

Complete all that apply: Date Certified (CRTT or CRT) - _____
Date Registered (RRT) - _____ Registry No. _____

(NBRC Official's Signature)

**Please mail directly to: Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243**

ATTACHMENT #2



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 532-3202
1-800-778-4123 ext 741-3807
CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license / certificate / registry to practice _____ with **(check one)** License Certificate Registry number _____
(Profession)
on (Date) _____ in the State of _____.
The Board of Respiratory Care of Tennessee requests that I submit evidence of the current status of the license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Respiratory Care.
Date: _____

Applicant's Signature

Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As It Appears On License/Certificate or Permit: _____
License/Certificate/Permit Number: _____ Profession: _____
Date Issued: _____
Basis of issuance _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
The License is currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____
If yes, Please attach supporting documentation.

Authorized Signature Title Date

ATTACHMENT #3



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive, 2nd Floor
NASHVILLE, TN 37243

BOARD OF RESPIRATORY CARE
(615) 532-3207
1-800-778-4123 ext 741-3807
EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your respiratory care educational program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a respiratory care practitioner in the State of Tennessee. The Board of Respiratory Care requires verification of educational attainment. Please forward an original transcript, identifying The Respiratory Care completion date and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Board of Respiratory Care
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

Thank you for your cooperation and prompt response.

Applicant's Signature

Date

MW/G3076269/RC



ATTACHMENT #4

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243
(615) 532-3202 OR 1-800-778-4123 EXT 741-3807
DECLARATION OF CITIZENSHIP**

MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The “SAVE Act” requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a “qualified alien,” or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ <div style="text-align: center; font-size: small;">Healthcare Profession (Please Print)</div>	_____ <div style="text-align: center; font-size: small;">License number if applicable</div>
--	--

Please Print Legibly

1. Name: _____

Last
First
Middle
Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver’s License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
- a) Permanent Residents
 - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 et seq.).
 - c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
 - d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
 - e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
 - f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
 - g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
 - h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming qualified alien status (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card or "Green Card")
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorization Card)
- Machine Readable Immigrant Visa (with Temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94)
- I-94 (Arrival/Departure record)
- Unexpired foreign passport
- WT/WB Admission Stamp in unexpired foreign passport
- I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

Signature

Sworn to before me this _____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.