MONTANA BOARD OF RESIPRATORY CARE PRACTITIONERS
301 SOUTH PARK, 4th FLOOR
PO BOX 200513
HELENA MONTANA 59620-0513
Phone: (406) 841-2391 or 2385 Fax: (406) 841-2305
Email: dlibsdrcp@mt.gov
Website: www.respcare.mt.gov

REQUIREMENTS AND APPLICATION INSTRUCTIONS

Incomplete applications will be returned with a statement regarding incomplete portions. Once an application is complete, estimated time of issuance of a license is 5-7 days.

RESPIRATORY CARE PRACTITIONER LICENSE

Qualifications for Licensure: Applicants for licensure must: {MCA 37.28.202}

- Complete a respiratory care educational program accredited or provisionally accredited by the American Medical Association's Committee on Allied Health Education and Accreditation in collaboration with the Joint Review Committee for Respiratory Therapy Education or their successor organizations; www.coarc.com.
- High School diploma or equivalent;
- Pass the National Board for Respiratory Care (NBRC) examination www.nbrc.org.
- Previously licensed Respiratory Therapists applying to Montana who have been away from practice for more than three years shall provide evidence of competency. These applications will be reviewed on a case by case basis by the Board.

Fees:

- $100.00 Application and License fee

Application Procedures: A fully-completed application for licensure, which is signed, shall be submitted with the following documents:

- Submit a recent, passport-type photograph. {ARM 24.213.402}
- Current copy of the NBRC certificate and wallet card. {ARM 24.213.402}
- Application and License fee in the amount of $100.00. Make check or money order payable to the Board of Respiratory Care Practitioners. All fees are non-refundable. Do not send cash. {ARM 24.213.401}
- If currently or previously licensed in another state or jurisdiction, a License/Verification/History must be sent to this office directly from those states or jurisdictions. {MCA 37.1.304}

Processing Procedures

- Once a routine application is complete, the application takes up to 5-7 days to process from the date it is received in the Board office.
- The applicant will be notified in writing of any deficient or missing items from the application file. Applicants will have 60 days from the date of notification to remit any missing items or the application will be considered voluntarily withdrawn and an entirely new application will need to be submitted. {ARM 24.213.402(6)}
- Once a routine application is processed and approved, a permanent license will be issued.

For information with regard to the processing of this application or other concerns, please contact the Board of Respiratory Care Practitioners staff at (406) 841-2391 or (406) 841-2385 or email us at dlibsdrcp@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF RESPIRATORY CARE ON OUR WEBSITE AT www.respcare.mt.gov

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APPLICATION FOR LICENSURE AS:

☐ **RESPIRATORY CARE PRACTITIONER**

1. FULL NAME _____
Last First Middle

2. OTHER NAME(S) KNOWN BY _____

3. BUSINESS NAME _____

4. BUSINESS ADDRESS _____
Street or PO Box # City and State Zip

5. HOME ADDRESS _____
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS ☐ Business ☐ Home

Email Address _____

6. TELEPHONE _____
Business Home Fax

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE

9. LICENSE NAME _____
(State your name as it should appear on the license if granted.)

10. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

11. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

12. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

13. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

14. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. ☐ Yes ☐ No

15. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

16. Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

17. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/ Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

18. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. ☐ Yes ☐ No

19. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. ☐ Yes ☐ No

20. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. ☐ Yes ☐ No

21. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. ☐ Yes ☐ No

22. Do you have any criminal charges pending or have you ever pled guilty, forfeited bond, or been convicted of a crime (whether or not sentence was suspended or deferred), or have you pled no contest or had prosecution deferred whether or not an appeal is pending? If yes, attach a detailed explanation and documentation from the source. You must report but may omit documentation for: (1) misdemeanor traffic violations resulting in fines of less than $100; and (2) charges or convictions prior to your 18th birthday unless you were tried as an adult. ☐ Yes ☐ No

23. Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. ☐ Yes ☐ No

24. Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. ☐ Yes ☐ No

25. Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source. ☐ Yes ☐ No

26. Have you taken the NBRC Exam? (If yes, complete the following

EXAM TYPE	RESULTS	DATES

27. Do you currently hold a license in another state as a Respiratory Care Practitioner or Limited Permit? If yes, provide the following information.

License Type	State	License Number	Date Issued	Current: Yes/No
				☐ Yes ☐ No
				☐ Yes ☐ No

28. **EDUCATION:**
List all colleges, universities, or course(s) that you have attended and/or completed.

College/University	Course	Date Attended	Number of Credits Hours	Months

29. Experience: Provide all locations in which you have practiced in the last three (3) years. (Please use additional sheets if necessary).

Name of Facility	Address	Dates (From/To)

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information , to the Montana Board of RESPIRATORY CARE PRACTITIONERS.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Signature of Applicant _____ Date _____

Please Place
Recent
Photograph
Here

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REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE
(THIS IS NOT AN ENDORSEMENT CERTIFICATION)

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold, or ever have held a license.

COMPLETE THE FORM AND MAIL IT TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERFICATION BE SENT TO THE MONTANA BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

LICENSEE INFORMATION

To Whom It May Concern:
I am applying for a license to practice as a Respiratory Care Practitioner in the State of Montana, and the Board of Respiratory Care Practitioners requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

Montana Board of Respiratory Care Practitioners
PO Box 200513
Helena, MT 59620-0513.

Your prompt response is appreciated.

Name (Please Print) _____ Signature _____

Address: _____

_____
Street or PO Box # City State Zip

My License Number from your State is: _____ License Type: _____