Rules of
Department of Economic Development
Division 255—Missouri Board for Respiratory Care
Chapter 2—Licensure Requirements

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Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT  
Division 255—Missouri Board for Respiratory Care  
Chapter 2—Licensure Requirements  
4 CSR 255-2.010 Application for Licensure

PURPOSE: This rule outlines the procedure for application for licensure as a respiratory care practitioner.

(1) Application for licensure shall be submitted on the forms provided by the board and may be obtained by writing the board at 3605 Missouri Boulevard, P.O. Box 1335, Jefferson City, MO 65102 or by calling (573) 522-5864. The TDD number is (800) 735-2966.

(2) An application is not considered officially filed with the board until it has been determined by the board or division staff to be complete and the application is submitted on the form provided by the board, typewritten or printed in black ink, signed, notarized and accompanied by application fee pursuant to rules promulgated by the board, a full set of fingerprints with the appropriate fee as defined by the rules promulgated by the board and any other applicable forms. All information should be received by the board within ninety (90) days of the date of the application.

(3) The applicant shall request that the National Board for Respiratory Care (NBRC) or its successor organization(s) send a letter directly to the board verifying the applicant’s credentials. The applicant is responsible for the payment of any fees required by the NBRC for the issuance of a verification letter.

(4) The applicant shall request that each state, United States Territory, province, or country regulatory entity in which a license, certificate, registration or permit as a respiratory care practitioner, respiratory therapist, respiratory therapy technician or similar title is held or has ever been held to submit verification of licensure, certification, registration or permit directly to the board. The verification shall include the license, registration, certification or permit issued, the number, status, issue and expiration dates, information regarding any disciplinary action, method of licensure, registration or certification, the name and title of person verifying information with date and board seal.

(5) The applicant shall submit a full set of fingerprints with the appropriate fee pursuant to rules promulgated by the board unless the applicant previously submitted fingerprints for a temporary or educational permit issued by the board.

(A) For the purpose of this rule, fingerprints shall be obtained from a law enforcement agency or may be obtained from the Missouri Board for Respiratory Care. Applicants desiring fingerprinting by the board shall contact the board at least twenty-four (24) hours in advance to schedule an appointment during normal business hours.

(6) Following review by the board, the applicant shall be informed in writing of the decision regarding the application for licensure. Applicants that are approved for licensure will receive one (1) license certificate. Duplicate licenses may be provided upon payment of the appropriate fee pursuant to rules promulgated by the board.


*Original authority: 334.800, RSMo 1996; 334.840, RSMo 1996; 334.850, RSMo 1996; and 334.870, RSMo 1996.
APPLICATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER

INSTRUCTIONS

• Please read this form before completing.
• This form must be typed or printed legibly in black ink.
• Provide complete information (Incomplete information will delay review of your application).
• Enclose the $65.00 application fee made payable to the Missouri Board for Respiratory Care. Payment must be made in the form of a check or money order.
• Request that the National Board for Respiratory Care (NBRC) send verification of your credentials directly to the Missouri Board for Respiratory Care (Copies of certificates or wallet cards issued by the NBRC are not acceptable). A verification request form is provided with this application.
• Obtain fingerprints upon the card that is enclosed with this application. Fingerprints must be obtained from a law enforcement agency or at the Board's Office.
• If you are or have ever been licensed, certified, registered or been granted a permit as a respiratory care practitioner by another state, territory of the United States, or province or country, request that verification of your license, registration, certification or permit be submitted by each state, territory, province or country upon the enclosed verification of licensure form. This form must be received directly from the other state(s), territory, country or province in which a license, certification, registration or permit was held.
• Affix a recent photograph of yourself in the space provided to the right of this section.

This application is being submitted on the basis of:
☐ New Applicant ☐ Reciprocity ☐ Reinstatement

APPLICANT DATA
NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN) ____________________________

SOCIAL SECURITY NUMBER* ___________ DATE OF BIRTH ___________ RESIDENCE TELEPHONE NUMBER ___________

RACE (THIS INFORMATION IS VOLUNTARY) ___________ GENDER (THIS INFORMATION IS VOLUNTARY) ___________

RESIDENCE STREET ADDRESS (IF PO BOX, PLEASE ALSO PROVIDE A STREET ADDRESS) ___________ CITY ___________ STATE ___________ ZIP ___________

CURRENT PLACE OF EMPLOYMENT ___________ EMPLOYMENT TELEPHONE NUMBER ___________

EMPLOYMENT ADDRESS ___________ CITY ___________ STATE ___________ ZIP ___________

WERE YOU REGISTERED WITH THE STATE OF MISSOURI, OFFICE OF HEALTH CARE PROVIDERS AS A RESPIRATORY CARE PRACTITIONER?
☐ YES ☐ NO

EDUCATION (Also include any military medical training) (If additional space is needed please attach sheets as necessary.)

<table>
<thead>
<tr>
<th>COLLEGE, UNIVERSITY OR PROFESSIONAL SCHOOL</th>
<th>CITY/STATE</th>
<th>DATES ATTENDED</th>
<th>DEGREE OR CERTIFICATE AWARDED</th>
<th>MAJOR COURSE OF STUDY</th>
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<td>MON</td>
<td>YR</td>
<td>MON</td>
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*SEE ENCLOSED NOTICE

PAGE 1
NATIONAL CREDENTIALS
☐ I HOLD THE FOLLOWING CREDENTIAL(S) ISSUED BY THE NATIONAL BOARD FOR RESPIRATORY CARE (NBRC):
☐ CERTIFIED RESPIRATORY THERAPY TECHNICIAN, (CRTT), ISSUE DATE:
☐ REGISTERED RESPIRATORY THERAPIST, (RRT), REGISTRY NUMBER:
HAVE YOUR CREDENTIALS EVER BEEN DISCIPLINED, SANCTIONED, SUSPENDED OR REVOKED? IF YES, EXPLAIN.
☐ YES  ☐ NO

PROFESSIONAL EXPERIENCE - LIST ALL EMPLOYERS IN THE PAST FIVE YEARS
BEGIN WITH THE MOST RECENT EMPLOYMENT, USING ADDITIONAL SHEETS IF NECESSARY

A. NAME AND ADDRESS OF EMPLOYER

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>NATURE OF BUSINESS</th>
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<tbody>
<tr>
<td>MON. YR.</td>
<td>MON. YR.</td>
<td>IMMEDIATE SUPERVISOR'S NAME AND ADDRESS</td>
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<td></td>
<td>TITLE OF APPLICANT'S POSITION</td>
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<tr>
<td></td>
<td></td>
<td>LENGTH OF EXPERIENCE IN THIS POSITION (YEARS, MONTHS)</td>
</tr>
</tbody>
</table>

B. NAME AND ADDRESS OF EMPLOYER

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<tr>
<th>FROM</th>
<th>TO</th>
<th>NATURE OF BUSINESS</th>
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<td>LENGTH OF EXPERIENCE IN THIS POSITION (YEARS, MONTHS)</td>
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C. NAME AND ADDRESS OF EMPLOYER

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<td>TITLE OF APPLICANT'S POSITION</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LENGTH OF EXPERIENCE IN THIS POSITION (YEARS, MONTHS)</td>
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</tbody>
</table>
Licensure, Certification or Registration

The applicant must answer the following questions. If any of the questions are answered yes, the applicant must provide an explanation.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been issued a professional license, certification, registration, or permit by any State, United States Territory, province or country? If yes, please list the state, territory, province or country, type of license with license number, status of license, and your name as it appears on the license.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you ever been denied a professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? If yes, explain fully in a separate notarized statement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold? If yes, explain fully in a separate notarized statement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement.</td>
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<tr>
<td>6. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed, (excluding traffic violations)? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you currently, or did you within the past five years, use any prescription drug, controlled substance, illegal chemical substance, or alcohol, to the point where your ability to competently practice as a respiratory care practitioner would be affected? If yes, explain fully in a separate notarized statement.</td>
<td></td>
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</tr>
<tr>
<td>9. Are you now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program? If yes, explain fully in a separate notarized statement and attach verification of chemical or alcohol dependency treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception or malpractice related to your practice as a respiratory care practitioner? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.</td>
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<td></td>
</tr>
<tr>
<td>11. Do you have a medical condition that in any way impairs or limits your ability to perform with reasonable care and safety the essential functions of a respiratory care practitioner with or without reasonable accommodations? If yes, explain fully in a separate notarized statement.</td>
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</tbody>
</table>
SWORN AFFIDAVIT

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a license to practice respiratory care in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit in consideration this application as required by the Missouri law governing the practice of respiratory care and subject to the rules and regulations of the Missouri Board for Respiratory Care. I subscribe and agree to abide by all applicable laws and rules regarding the practice of respiratory care. I hereby certify that I have familiarized myself with sections 334.800-334.930 RSMo, known as the Respiratory Care Practice Act and applicable rules promulgated by the Missouri Board for Respiratory Care.

Enclosed is the application fee which is not refundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

MUST BE SIGNED IN PRESENCE OF NOTARY

SIGNATURE OF APPLICANT

STATE OF

COUNTY (OR CITY OF ST. LOUIS)

SUBSCRIBED AND SWORN BEFORE ME THIS

DAY OF

19

NOTARY PUBLIC SIGNATURE

MY COMMISSION EXPIRES

NOTARY PUBLIC NAME (TYPED OR PRINTED)

USE RUBBER STAMP IN CLEAR AREA BELOW.
REQUEST FOR VERIFICATION OF CREDENTIALS

INSTRUCTIONS:

TO APPLICANT:
Please complete Section I below. Current registry members must forward a $3 credential verification fee.
Non-current members must forward a $15 credential verification fee to:
National Board for Respiratory Care, Inc.
8310 Nieman Road
Lenexa, Kansas 66214
Telephone: (913) 599-4200

TO NBRC:
Please complete Section II below and return completed form to:
Missouri Board for Respiratory Care
P O Box 1335
Jefferson City, MO 65102-1335
Telephone: (573) 522-5864

SECTION I

I am applying for state licensure in Missouri, and I am requesting the NBRC verify my respiratory therapy credentials directly to the Missouri Board for Respiratory Care.

I HOLD THE FOLLOWING NBRC CREDENTIALS:  □ RRT  □ CRRT

DATE CREDENTIALS EARNED

PRINT NAME UNDER WHICH YOU WERE CREDITED (LAST, FIRST, MIDDLE INITIAL)

APPLICANT FULL NAME (PLEASE PRINT) (LAST, FIRST, MIDDLE INITIAL)  SOCIAL SECURITY NUMBER

SIGNATURE  DATE

SECTION II (For NBRC Use Only)

The above named person has achieved the minimum passing score required for successful completion of an examination and earned the following NBRC credentials:

<table>
<thead>
<tr>
<th>CREDENTIALS</th>
<th>DATE CREDENTIALED</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ CRRT</td>
<td></td>
</tr>
<tr>
<td>□ RRT</td>
<td>(NUMBER ___________ )</td>
</tr>
</tbody>
</table>

SIGNATURE  DATE

NOT VALID UNLESS STAMPED BY NBRC (IN SPACE BELOW)

MO 419-0508 (11-97)
VERIFICATION OF LICENSURE

INSTRUCTIONS
Complete Section I and mail this form to each state, United States Territory, province or country that you have or ever have had a license, certification, registration, temporary license or a temporary permit to practice respiratory care. This verification must be returned to the Missouri Board for Respiratory Care within ninety (90) days of your application. Some states do require a fee for providing verification information. To expedite your application, you may wish to contact the applicable state(s), U.S. territory, province or country. This form may be photocopied as necessary.

SECTION I - TO BE COMPLETED BY APPLICANT

NAME (FIRST; MIDDLE; LAST, SUFFIX)

NAME AS IT APPEARS ON LICENSE/CERTIFICATION/REGISTRATION/PERMIT

TYPE OF LICENSE/CERTIFICATION/REGISTRATION/PERMIT HELD

NUMBER ISSUED

SOCIAL SECURITY NUMBER

DATE OF BIRTH

The Missouri Board for Respiratory Care requests that I submit evidence of the status of my license, certification, registration, permit in your state. You are hereby authorized to release any information in your possession pertaining to me, favorable or otherwise, directly to the Missouri Board for Respiratory Care, P.O. Box 1335, Jefferson City, MO 65102.

APPLICANT SIGNATURE

DATE

SECTION II - TO BE COMPLETED BY ADMINISTRATIVE OFFICE OF OTHER REGULATORY AGENCY

TYPE OF REGULATION

☐ LICENSE ☐ CERTIFICATION ☐ REGISTRATION ☐ PERMIT HOLDER

LICENSE NUMBER

ISSUE DATE

EXPIRATION DATE

LICENSE WAS ISSUED ON THE BASIS OF

☐ NBRC CREDENTIALS ☐ STATE EXAMINATION ☐ EDUCATION ☐ GRANDFATHER CLAUSE

☐ OTHER

HAS THE APPLICANT'S LICENSE EVER Lapsed?

☐ YES ☐ NO IF YES, EXPLAIN

HAS THE APPLICANT EVER BEEN RESTRICTED OR DISCIPLINED IN ANY WAY?

☐ YES ☐ NO IF YES, EXPLAIN

DOES THE APPLICANT HAVE ANY PENDING COMPLAINTS?

☐ YES ☐ NO IF YES, EXPLAIN

SIGNATURE

DATE

NAME PRINTED

TITLE

PLEASE AFFIX BOARD SEAL

MO 419-2276 (12/97)
4 CSR 255-2 Application for Temporary Permit

PURPOSE: This rule outlines the procedure for application for a temporary permit.

(1) Application for a temporary permit shall be submitted on the forms provided by the board and may be obtained by writing the board at 3605 Missouri Boulevard, P.O. Box 1335, Jefferson City, MO 65102 or by calling (573) 522-5864. The TDD number is (800) 735-2906.

(2) An application for a temporary permit is not considered officially filed with the board until it has been determined by the board or division staff to be complete and the application is submitted on the form provided by the board, typewritten or printed in black ink, signed, notarized and accompanied by the application fee for temporary permit pursuant to rules promulgated by the board, verification of respiratory care work experience, and a full set of fingerprints with the appropriate fee pursuant to rules promulgated by the board. All information should be received by the board within ninety (90) days of application.

(3) The applicant shall request and obtain on forms provided by the board verified evidence of—

(A) Performance of the duties of a respiratory care practitioner for the previous twelve (12) months as defined in section 334.800, RSMo and evidence of being a veteran of the United States military services with at least six (6) months respiratory care experience as a member of the military; or

(B) Performance of the duties of a respiratory care practitioner for the previous twelve (12) months as defined in section 334.800, RSMo and evidence of six (6) months respiratory care experience in a United States territory or foreign country; or

(C) Special on-the-job training and the performance of the duties of a respiratory care practitioner on August 28, 1996.

(4) The applicant shall request that each state, United States territory, province, or country regulatory entity in which a license, certificate, registration or permit as a respiratory care practitioner, respiratory therapist, respiratory therapy technican or similar title is held or has ever been held to submit verification of licensure, certification, registration or permit directly to the board. The verification shall include the license, registration, certification or permit issued, the number, status, issue and expiration dates, information regarding any disciplinary action, method of licensure, registration or certification, the name and title of person verifying information with date and board seal.

(5) The applicant shall submit a full set of fingerprints on the form provided by the board with the appropriate fee pursuant to rules promulgated by the board, unless the applicant previously submitted fingerprints for an educational permit issued by the board.

(A) For the purpose of this rule, fingerprints shall be obtained from a law enforcement agency or may be obtained from the Missouri Board for Respiratory Care. Applicants desiring fingerprinting by the board shall contact the board at least twenty-four (24) hours in advance to schedule an appointment during normal business hours.

(6) The applicant shall submit registration of supervision on forms provided by the board.

(7) Following review by the board, the applicant shall be informed in writing of the decision regarding the application for permit. Applicants that are approved will receive one (1) permit. Duplicate permits may be provided upon payment of the appropriate fee pursuant to rules promulgated by the board.

(8) The permit holder must notify the board of any change in supervision within fifteen (15) days of the change.


*Original authority: 334.800, RSMo 1996; 334.840, RSMo 1996; 334.850, RSMo 1996; and 334.890, RSMo 1996.
MISSOURI
DEPARTMENT OF ECONOMIC DEVELOPMENT

APPLICATION FOR PERMIT

INSTRUCTIONS

- Please read this form before completing.
- This form must be typed or printed legibly in black ink.
- Provide complete information (Incomplete information will delay review of your application).
- Enclose the application fee made payable to the Missouri Board for Respiratory Care. Payment must be made in the form of a check or money order.
- Obtain fingerprints upon the card that is enclosed with this application. Fingerprints must be obtained from a law enforcement agency or at the Board's Office.
- A permit holder may only perform and provide services of a respiratory care practitioner under the direct clinical supervision of a licensed respiratory care practitioner. Supervisors must be approved by the Board. Have your supervisor complete the enclosed supervision registration form and submit the form with this application.
- If you are or have ever been licensed, certified, registered or been granted a permit as a respiratory care practitioner by another state, territory of the United States, province or country request that verification of your license, registration, certification, or permit be completed by each state, territory, province or country upon the enclosed verification of licensure form. This form must be received directly from the other state(s), territory, province or country in which a license, certification, registration or permit was held.
- Affix a recent photograph of yourself in the space provided to the right of this section.

RETURN NOTARIZED APPLICATION FORM, SUPERVISION REGISTRATION, FEE AND FINGERPRINTS TO:
MISSOURI BOARD FOR RESPIRATORY CARE
3605 MISSOURI BOULEVARD
P.O. BOX 1335
JEFFERSON CITY MO 65102-1335
TELEPHONE: (573) 522-5864
TDD: (800) 735-2966

AFFIX PHOTOGRAPH

TYPE OF APPLICATION:

☐ Temporary Permit (this permit may be issued only once to an individual and is valid for eighteen (18) months)

Application Fee: $50

The Missouri Board for Respiratory Care must receive verification of your work experience directly from a supervisor, medical director, department director or human resource department on the enclosed verification of work experience form.

I am submitting this application based upon the fact that (check all that apply):

☐ 1. I have six (6) months of verifiable military experience in the practice of respiratory care; or

☐ 2. I have been performing the duties of a respiratory care practitioner as defined in Section 334.800, RSMo, of the Respiratory Care Practice Act for the previous twelve (12) months in a U.S. territory or foreign country; or

☐ 3. I have had special on-the-job training in the practice of respiratory care on August 28, 1996 and am currently performing the duties of a respiratory care practitioner as defined in Section 334.800, RSMo, of the Respiratory Care Practice Act.

☐ Temporary Educational Permit (this permit may be issued to an individual that is currently enrolled in an accredited respiratory care program and is valid up to twelve (12) months after completion of the educational program)

Application Fee: $25

You must have the enclosed verification of education form completed and mailed directly to the Missouri Board for Respiratory Care.

APPLICANT DATA

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)

SOCIAL SECURITY NUMBER*  
DATE OF BIRTH  
RESIDENCE TELEPHONE NUMBER  

NAME (THIS INFORMATION IS VOLUNTARY)  
GENDER (THIS INFORMATION IS VOLUNTARY)

RESIDENCE STREET ADDRESS (IF P.O. BOX, PLEASE ALSO PROVIDE A STREET ADDRESS)  
CITY  
STATE  
ZIP

CURRENT PLACE OF EMPLOYMENT

EMPLOYER ADDRESS

EMPLOYMENT ADDRESS

CITY  
STATE  
ZIP

MO 419-2272 (8-98)  
*SEE ENCLOSED NOTICE

Rebecca McDowell Cook  (12/31/98)  
Secretary of State

CODE OF STATE REGULATIONS

11
### EDUCATION

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<tr>
<th>College, University or Professional School</th>
<th>City/State</th>
<th>Dates Attended</th>
<th>Degree or Certificate Awarded</th>
<th>Major Course of Study</th>
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### PROFESSIONAL EXPERIENCE

Begin with the most recent employment, using additional sheets if necessary.

A. Name and Address of Employer

<table>
<thead>
<tr>
<th>Nature of Business</th>
<th>From</th>
<th>To</th>
<th>Immediate Supervisor's Name and Address</th>
<th>Title of Applicant's Position</th>
<th>Months Experience</th>
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B. Name and Address of Employer

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Respiratory Duties Performed

...
Chapter 2—Licensure Requirements

C. NAME AND ADDRESS OF EMPLOYER

NATURE OF BUSINESS

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>IMMEDIATE SUPERVISOR’S NAME AND ADDRESS</th>
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<th>MON. YR.</th>
<th>MON. YR.</th>
<th>TITLE OF APPLICANT'S POSITION</th>
<th>MONTHS EXPERIENCE</th>
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RESPIRATORY DUTIES PERFORMED

LICENSURE, CERTIFICATION OR REGISTRATION

The applicant must answer the following questions. If any of the questions are answered yes, the applicant must provide an explanation.

1. Have you ever been issued a professional license, certification, registration, or permit by any State, United States Territory, province or country? If yes, please list the state, territory, province or country, type of license with license number, status of license, and your name as it appears on the license. □ □

2. Have you ever been denied a professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement. □ □

3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? If yes, explain fully in a separate notarized statement. □ □

4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold? If yes, explain fully in a separate notarized statement. □ □

5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration, or permit? If yes, explain fully in a separate notarized statement. □ □

6. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed, (excluding traffic violations)? If yes, explain fully in a separate notarized statement and attach certified copies of court documents. □ □

7. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed? If yes, explain fully in a separate notarized statement and attach certified copies of court documents. □ □
8. Do you currently, or did you within the past five years, use any prescription drug, controlled substance, illegal chemical substance, or alcohol, to the point where your ability to competently practice as a respiratory care practitioner would be affected? If yes, explain fully in a separate notarized statement.

   YES ☐ NO ☐

9. Are you now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program? If yes, explain fully in a separate notarized statement and attach verification of chemical or alcohol dependency treatment.

   YES ☐ NO ☐

10. Have you ever had a judgment rendered against you based upon fraud, misrepresentation, deception or malpractice related to your practice as a respiratory care practitioner? If yes, explain fully in a separate notarized statement and attach certified copies of court documents.

   YES ☐ NO ☐

11. Do you have a medical condition that in any way impairs or limits your ability to perform with reasonable care and safety the essential functions of a respiratory care practitioner with or without reasonable accommodations? If yes, explain fully in a separate notarized statement.

   YES ☐ NO ☐

**SWORN AFFIDAVIT**

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a permit to practice respiratory care in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit in consideration this application as required by the Missouri law governing the practice of respiratory care and subject to the rules and regulations of the Missouri Board for Respiratory Care. I subscribe and agree to abide by all applicable laws and rules regarding the practice of respiratory care. I hereby certify that I have familiarized myself with sections 334.800-334.930 RSMo, known as the Respiratory Care Practice Act and applicable rules promulgated by the Missouri Board for Respiratory Care.

I understand that I must perform respiratory care services only under the direct clinical supervision of a licensed respiratory care practitioner as approved by the Missouri Board for Respiratory Care. If, for any reason the arrangements for my supervision should change, I will notify the Missouri Board for Respiratory Care immediately.

Enclosed is the application fee which is not refundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

**MUST BE SIGNED IN PRESENCE OF NOTARY**

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