ATTENTION!

Criminal History Record Checks (CHRC) are required for all applicants. The Board may not reinstate or issue a new license to any applicant, physician or allied health practitioner, if the Board has not received criminal history record information.

The Board recommends that you do not submit your fingerprints for a CHRC earlier than 6 weeks before the date you intend to submit your initial license or reinstatement application to the Board.

The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

For detailed instructions on submitting your fingerprints for a CHRC, please read and follow the attached instructions.
Notice: Criminal History Records Check Required

Dear Applicant for Initial License or Reinstatement of License:

A full Criminal History Records Check (CHRC) is a qualification of licensure. The Board may not reinstate or issue a new license to any applicant, physician, or allied health practitioner, if the Board has not received criminal history record information.

A CHRC will include both a State and national criminal history records check conducted by the Maryland Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) and will be maintained in the Maryland and FBI database for further identification purposes. Applicants have the right to challenge their records, which is discussed in more detail in the FBI NonCriminal Justice Applicant's Privacy Rights notice (https://www.mbp.state.md.us/forms/fbi_privacy_rights.pdf). An applicant for initial licensure or reinstatement shall apply to CJIS for a CHRC and the application shall include:

1. Two complete sets of legible fingerprints taken on forms approved by CJIS and the FBI; and
2. Payment of the required fees.

Timing of CHRCs

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

Fingerprints

A. For Initial Applicants and Reinstatements

All applicants for licensure in Maryland will be required to submit fingerprints for the CHRC. In order to be fingerprinted, the fingerprinting entity will need the following Board specific information:

- CJIS Authorization #: 1600000743
- FBI ORI #: MD 920522Z
- Reason Fingerprinted: Professional License
- Type of Check: Governmental Licensing/ Certification
1. **Within Maryland**
   a. Go to an authorized location to be fingerprinted prior to mailing in your application to the Board. For a list of electronic fingerprinting locations go to the following website: [https://www.dpscs.state.md.us/publicservs/fingerprint.shtml](https://www.dpscs.state.md.us/publicservs/fingerprint.shtml). The Board is not responsible for the list. If there are any concerns about a fingerprinting location, please contact CJIS directly.
   b. Provide the fingerprinting entity the CJIS Authorization number and FBI ORI # provided on page 1 of this letter.
   c. Pay the appropriate fee to the fingerprinting entity.

Once the Board receives the results of the CHRCs, the application process will be completed in accordance to Board regulations and policies.

2. **Outside of Maryland**
   a. Out of state applicants have the option of using a Maryland location for fingerprinting. If a Maryland location is used, follow the instructions above for applicants within Maryland. If a location outside of Maryland is used, follow the instructions below.
   b. Either:
      i. Write to CJIS-Central Repository at P.O Box 32708, Pikesville, Maryland 21282-2708, or
      ii. Call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request fingerprint cards.
   c. Have CJIS Authorization and FBI ORI Board #’s available to complete your submission.
   d. Mail the fingerprint card and associated fee to CJIS-Central Repository, P.O Box 32708, Pikesville, Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
   e. Please include a check or cashier’s check made out to “CJIS Central Repository”.

Once the Board received the results of the CHRCs, the application process will be completed in accordance to the Board regulations and policies.

---

**Timing of CHRCs**

The Board recommends that applicants do not submit fingerprints earlier than 6 weeks before the date the applicant/licensee intends to complete the initial license or reinstatement application. The Board is only authorized to retain CHRC information for 90 days. If the CHRC is over 90 days, the applicant will be required to complete a new CHRC.

---

**Fees:**

Fees are required for CJIS to process each criminal background record check request. All fees must be paid by credit card, check or cashier’s check in United States currency. The Central Repository cannot accept cash.

Do not send any payment to the Board, as it does not conduct CHRCs. For additional information contact CJIS at 410-764-4501 or visit [https://www.dpscs.state.md.us/publicservs/fingerprint.shtml](https://www.dpscs.state.md.us/publicservs/fingerprint.shtml).
Questions?

Should you have any questions, concerns, or to check the status of a criminal history record information request, please contact the CJIS Call Center at 410-764-4501 or 1-888-795-0011, Monday-Friday 8:00 a.m. - 5:00 p.m. The Board cannot assist you in this regard.

*Please do not contact the Board to verify receipt or submit receipts. The Board will receive the electronic CHRC notifications within 3 – 14 days.
Dear Applicant:

Attached is an application packet for licensure as a Respiratory Care Practitioner in Maryland. The application fee is $200.00 and non-refundable. Please make your check or money order payable to: Maryland Board of Physicians. Mail your application and check to:

Maryland Board of Physicians
P.O. Box 37217
Baltimore, MD 21297

Please DO NOT mail or hand deliver your application to the Board of Physician’s (the Board) office or any other address except the address listed above. Applications mailed or hand delivered to the Board office will be forwarded to the above address. This will delay the processing of your application. Please note: Federal Express (FEDEX) or UPS do not deliver to post office boxes.

Applications are processed in order of receipt. Please allow at least 3 to 6 weeks for the processing of your application. Board staff will make every effort to process your application as quickly as possible. Incomplete applications and/or failure to submit the required information will delay the processing of your application.

Board staff will contact you if additional documentation is required. Please make sure your contact information is current. Please do not call the Board to check on the status of your application, as constant interruptions slow down the process.

Documents submitted to support your application must come directly from the source. For example, verification of education must come directly from your school and verification of other licenses must come from the state board that issued your license. The Board will verify the National Board for Respiratory Care (NBRC) CRT/RRT credential on the NBRC’s website. In the event that it cannot be verified online, Board staff will require the Applicant to have the BRPT send written verification to the Board.

Board staff will not disclose the status of your application to another party unless you have completed the Third Party Option on page 7 of the application. Please complete the third party release if you want your application disclosed to family members, friends, and future employers, etc.

The Board will keep your application open for 120 days from the original date of receipt. All requirements for licensure must be met within the 120-day period. If the requirements are not met, your application will be closed and a new application and full application fee will be required.

The Board’s Website is updated every 24 hours. You may wish to check the Website at www.mbp.state.md.us/bpqapp before calling the Board to learn if a license was issued to you. When you visit the Website, click on Look up a Licensee.

We look forward to receiving your completed application and will process it as quickly as possible.

Thank you,

The Allied Health Division
Maryland Board of Physicians
APPLICATION FOR LICENSURE OF RESPIRATORY CARE PRACTITIONERS

INSTRUCTIONS AND IMPORTANT INFORMATION

If you have been previously licensed in Maryland as a respiratory care practitioner, DO NOT USE THIS APPLICATION. Download a copy of the reinstatement application from the Board’s website at www.mbp.state.md.us.

1. **Name**: If the name on the application form differs from the name on any of your supporting documentation, you must submit a copy of a marriage license, divorce decree, or a court order explaining the change of name. The Board must be notified of any change in your name on a timely basis.

2. **Non-Public Address**: The non-public (home) address will be the location to which the Board directs all correspondence. If your address changes during the application process, please notify the Board in writing.

3. **Public Address**: The public address (business address) is your address of record and available to the public. However, if no public address is listed, the non-public address will be made available to the public.

4. **Contact Information (Telephones and E-mail Address)**: The Board will contact you using the information provided.

5. **Date of Birth**: Health Occupations Article §14-5A-09(c), Annotated Code of Maryland requires applicants to be at least 18 years old. Date of birth will also be used for identification and criminal background checks.

6. **Gender**: Disclosure of gender is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

7. **Race and Ethnicity**: Disclosure of race or ethnicity is not a requirement of licensure, but the information provided will be used for identification purposes and for criminal background checks only.

8. **Social Security Number**: Maryland law requires the Board to collect social security numbers from all persons applying for professional licenses or certificates. Disclosure of your social security number is mandatory. The Board is permitted by State or Federal law or regulation to use the social security number for the following purposes:

   A. Verification of identity with respect to actions related to your license (Code of Maryland Regulations 10.32.01.);
   B. Administration of the Child Support Enforcement Program (Family Law Article, §10-119.3);
   C. Identification by the Department of Assessments and Taxation of new businesses in Maryland (Health Occupations Article, §1-210);
   D. Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid 42 U.S.C. §1396(a)(49); 42 U.S.C. §1396r-2; 42 U.S.C. §1320 a-7).
9. Employment Activities: Please complete and include all employment history beginning with the date you graduated from an accredited Respiratory Therapy educational program.

10. Verification of Professional Education: Complete the top portion of the Verification of Professional Education form (RCP 1) and forward it to the CoARC or CAAHEP accredited respiratory therapy program from which you graduated.

   If your school/program is no longer in existence, please either contact the Board of Higher Education or the Board of Education in the state where you attended the program. You may obtain the contact information by accessing www.statelocalgov.net/50states-education.cfm.

   You may also wish to contact the Commission on Accreditation of Allied Health Education Programs (CAAHEP) at www.caahep.org or the Committee on Accreditation for Respiratory Care (CoARC) at www.coarc.org. These agencies accredit respiratory care programs and may have information on closed schools/programs.

11. National Certification: Verification of certification from the National Board of Respiratory Care (NBRC). Applicants for licensure as a respiratory care practitioner must be currently certified by NBRC.

12. Oral and Written Competency in English: Demonstrate verbal and written competency in the English language by documentation of any of the following:

   a. Graduation from an English-speaking high school or undergraduate school after at least three (3) years of enrollment;

   b. Graduation from an English-speaking professional school; or

   c. Achievement of a passing score of at least 26 on the spoken part and 79 on the written part of the Test of English as a Foreign Language (TOEFL).

13. Licensure in Other States: If you have ever held a license, certification or registration to practice as a respiratory therapist in any state or jurisdiction or in ANY other health care profession in any other states, including Maryland, complete the top portion of the Verification of Other State Licenses form (RCP 2) and send it to the licensing board in each state in which you are or have been licensed/certified/registered. PLEASE check with the applicable state board to see if there is a fee required for this information prior to mailing the form. If you were licensed by the Board of Physicians in another profession, you do not need to complete the RCP 2 form.

14. Character and Fitness Questions: Answer the Character and Fitness questions "YES" or "NO." If you answer "YES" to any item, please provide a detailed explanation, on a separate sheet of paper, and any supporting documents. If you were dishonorably discharged from the military, please provide documentation that shows, including, but not limited to, the type of service, date and type of discharge, e.g. DD14. Failure to provide a detailed explanation of a “Yes” response and the required supporting documentation will delay the review process.
15. Release: Sign and date the certification. You are giving the Board and Respiratory Care Professional Standards Committee permission to request additional information to support your application for licensure.

16. Optional Third Party Release: If you wish the Board to release your information to a third party, complete the third party release statement.

17. Cooperation in an Investigation: You are expected to cooperate fully with any request for information related to your respiratory care practitioner application for licensure.

18. Certification and Passport Quality Photo: Sign and date the certification in the presence of a notary public after you have affixed a recent passport quality (2” x 2”) photo to the application in the space provided.

Supplemental Forms RCP 1 and RCP 2 - Verification of Education (RCP 1): Complete this form and send it to the institutions where you completed your CoARC or CAAHEP accredited educational program.

Verification of Other State Licenses (RCP 2): Complete this form if you were issued a license/certification/registration to practice as a respiratory therapist or ANY other health care provider.

Licence and Renewal: If your application is approved, you will receive an approval letter containing the license number assigned to you, the original date of licensure and expiration, and a license. Regardless of the date of initial licensure, your license will expire on May 30th of the first even year following the date on which you are initially licensed. You will be required to renew your license if you plan to continue practicing in Maryland. The renewal notice will be mailed or email to you at least 30 - 60 days prior to the expiration of your license to the most current street address or email address on file with the Board. You will be required to renew your license by May 30th of every even year whether or not you receive the renewal notice.

PRACTICING RESPIRATORY CARE: A person may not practice, attempt to practice, or offer to practice respiratory care in Maryland unless licensed to practice by the Board. A person may not provide, attempt to provide, offer to provide, or represent that the person provides respiratory care unless the person is licensed to practice by the Board.

The Maryland Board of Physicians supports the Americans with Disabilities Act (ADA) and will provide this material in an alternative format to facilitate effective communication with sensory impaired individuals (for example, Braille, large print, audio tape). If you need such accommodation, please notify the Board’s ADA designee, Yemisi Koya, at (410) 764-4777 or 1-800-492-6836. For the hearing impaired, please contact the Maryland Relay Services TTY/Voice number at 1-800-735-2258. If you have a complaint concerning the Board’s compliance with the ADA, please contact Ms. Koya.

Please keep a copy of your application.
ATTENTION

If You Are a Veteran, Service Member or Military Spouse

Complete ONLY if You Meet the Following Criteria

Check the appropriate box.

☐ Service Member — Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. Provide supporting documentation.

☐ Veteran — Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. Provide supporting documentation.

☐ Military Spouse: Check the appropriate box

☐ Spouse is a Veteran. Provide supporting documentation.

☐ Spouse was a service member who died within one year before the date of submitting the application. Provide supporting documentation.

☐ Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any state. Provide supporting documentation.

Name of Applicant (PRINT) ___________________________________________ Military Branch ___________________________________________
Please print legibly or type the required information. Do not leave any item unanswered.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

   Last name and generational indicator (Jr., Sr., II, III, etc.):

   First name and middle name:

   (If applicable, please check a box and complete below) □ Complete Maiden Name OR □ Complete Former Name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

   Street Address: (Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.

   City

   State

   Zip Code

3. **Public Address:** Your public address of record. This address, usually your place of employment, is available to the public and will be posted on the Internet.

   Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.

   City

   State

   Zip Code

4. **Telephone (s):** Home

   Office:

   Cell/Pager:

   E-mail address:

5. **Date of Birth:**

   Month

   Day

   Year

6. **Gender:**

   □ Male

   □ Female

7. **Race:** Check all that apply

   American Indian or Alaska Native

   Asian

   Black or African American

   Native Hawaiian or other Pacific Islander

   White

   Hispanic or Latino

   Not Hispanic or Latino

8. **Social Security Number:**

   □ □ □ □ - □ □ □ - □

   For Board Use Only

   License Number:

   Date Issued:

   Expiration Date:

   Licensed By: ____________________________
9. Chronology of Employment Activities: Beginning with the date you completed your Respiratory Therapy Program, list employment activities as a respiratory therapist. Also list any other health related employment. Explain any lapse over 1 year in which you were not employed. Please write N/A below if the statements do not apply to you. Please copy this page if you need more space. Sign and date all additional pages.

Graduation Date from accredited CAAHEP/CoARC Program:
Month: ______ Year: ______

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<thead>
<tr>
<th>Date</th>
<th>Activity/Position</th>
<th>Name and Address of Employer</th>
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If you will need more space than this page allows, please photocopy this page for your use. Please sign and date each sheet you attach.
10. EDUCATIONAL PROGRAM: Please complete this section and send the attached Verification of Professional Education (RCP 1) to your Respiratory Therapy program.

Name of School/Program

/ / 

Graduation Date

Degree and Type (Certificate, Associates, etc.)

Street Address

City State Zip Code

Telephone Number, including area code

11. National Certification: List the date and certification number.

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<tr>
<th>NBRC Designation</th>
<th>Certification #</th>
<th>Certification Date</th>
<th>Expiration Date</th>
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12. ORAL AND WRITTEN COMPETENCY IN ENGLISH (Check one)

- I graduated from a recognized English-speaking high school or undergraduate school after at least 3 years of enrollment;

  Name of high school: ________________________________
  City and state of high school: ________________________

- I graduated from a recognized English-speaking professional school; OR

- I achieved a passing score of at least 26 on the spoken part of the TOEFL and 79 on the written part of the TOEFL.

** Please attach a PDF copy of your score report to the application.
13 a. Licensure as a Respiratory Therapist. List all states or other jurisdictions in which ever held a license/certificate/registration to practice as a Respiratory Therapist. Please complete and mail the attached **Verification of Other State Licenses** form (RCP 2) to the appropriate state board(s). If you have never been licensed as a Respiratory Therapist, write N/A here ________________.

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<tr>
<th>State</th>
<th>License #</th>
<th>Category (CRT/RRT)</th>
<th>Year Issued</th>
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13 b. Licensure as another health care practitioner. List all states or other jurisdictions in which ever held a license/certificate/registration to practice in ANY other health occupation. Please complete and mail the attached **Verification of Other State License(s)** form (RCP 2) to the appropriate state board(s). If you have never been licensed in any other health occupation, write N/A here ____________________________.

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<th>State</th>
<th>License #</th>
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14. Character and Fitness Questions (Check either YES or NO) Please answer questions “a” through “q” on pages 5 and 6.

YES  NO

a. ☐  ☐ Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever denied your application for licensure, reinstatement, or renewal?

b. ☐  ☐ Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.

c. ☐  ☐ Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?

d. ☐  ☐ Have you ever withdrawn your application for a medical license or other health professional license?

e. ☐  ☐ Has a hospital, related health care institution, HMO, or alternative health care system ever investigated you or ever brought charges against you?

f. ☐  ☐ Has a hospital, related health care institution, HMO, or alternative health care system ever denied your application; failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?

g. ☐  ☐ Have you ever pleaded guilty or nolo contendere to any criminal charge, been convicted of a crime, or received probation before judgment because of a criminal charge?

h. ☐  ☐ Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.

i. ☐  ☐ Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?

j. ☐  ☐ Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

k. ☐  ☐ Have any malpractice claims or other claims for money damages ever been filed against you? Include past claims as well as any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.

If you answered “YES” to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.

Continue to Page 6 for questions “l” through “q”
14a. Character and Fitness Questions Continued (Check either YES or NO)

YES  NO

l. ☐  ☐ Are you in default of a service obligation that you incurred by receiving State or Federal funds for your medical education?

m. ☐  ☐ Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?

n. ☐  ☐ Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration ever been terminated for disciplinary reasons?

o. ☐  ☐ Have you ever voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?

p. ☐  ☐ Have you ever surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?

q. ☐  ☐ Have you ever been dishonorably discharged from any military service of the U.S. Government? If so, attach a copy of your military discharge documentation that includes type of service, date of discharge, and type of discharge.

>>> If you answered “YES” to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach appropriate supporting documents.

Failure to provide documentation and a signed and dated explanation will delay the processing of your application.
15. Release: I agree that the Maryland Board of Physicians (the Board) and the Respiratory Care Professional Standards Committee may request any information necessary to process my application for initial licensure as a Respiratory Care Practitioner in Maryland from any person or agency, including but not limited to the NBRC, former and current employers, government agencies, the National Practitioners Data Bank, Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

Applicant’s Name (Printed)  
Applicant’s Signature  
Date

16. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: ____________________________  
Phone: ____________________________  
Applicant’s Signature  
Date

17. Cooperation in an Investigation: I agree that I will cooperate fully with any request for information or with any investigation related to my practice as a licensed Respiratory Care Practitioner in Maryland, including the subpoena of documents and/or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-5A-14.

Applicant’s Signature  
Date

18. Certification: To be completed by the applicant in the presence of a notary public after the applicant’s picture has been attached below.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. I also certify that I am thoroughly familiar with the Statute (MD. Code Ann., Health Occ. 14-5A-01 et seq.) and Code of Maryland Regulations (COMAR) 10.32.11 which govern the practice of Respiratory Care Practitioners in Maryland.

Applicant’s Signature  
Date

STATE OF ____________________________  
CITY/COUNTY OF ____________________________

I HEREBY CERTIFY that on this __________ day of __________, 20 ____, before me ____________________________, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant ____________________________, whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law that signing the foregoing application was his/her voluntary act and deed.

AS WITNESS my hand and notorial seal. ____________________________

Notary Public

My Commission expires: ____________________________

APPLICANT:
PASTE YOUR PASSPORT-QUALITY PHOTO HERE BEFORE NOTARIZING

COPIES OF PHOTOS ARE NOT ACCEPTABLE

STOP! Completed application and check for $200 must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

PLEASE KEEP A COPY OF YOUR APPLICATION!
Respiratory Care Practitioners

Supplemental Forms

RCP 1—Verification of Professional Education (Accredited CRT/RRT Educational Program)

RCP 2—Verification of Other State Licenses
VERIFICATION OF PROFESSIONAL EDUCATION FOR
RESPIRATORY CARE PRACTITIONER LICENSURE

Part 1

APPLICANT: Complete Part 1 and send to the institution where you completed your Respiratory Therapy program.

Name: ____________________________________________

Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: ________/______/______

Social Security Number: ___________ - _______ - __________

Professional School of Graduation: ______________________________________

Attended from: ___________________________ to ___________________________

Date of Graduation: ________________

Degree Received: ___________________________________ mm/yyyy

Applicant's Signature:________________________________________

Date: ________________

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual graduated from this institution on: ______________________

Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree  ☐ Certificate  ☐ Bachelor's Degree  ☐ Master's Degree  ☐ Other: ____________________________ (specify)

in ___________________________.  The program was accredited by: ____________________________

Educational Program  CoARC, CAAHEP, CAHEA, etc.

Printed Name of Authorized Official ____________________________

Name of Institution ____________________________

Title of Authorized Official ____________________________

Telephone Number ____________________________

Fax Number ____________________________

Signature of Authorized Official ____________________________

Date ____________________________

SEAL
OF THE
INSTITUTION

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777  800-492-6836
www.mbp.state.md.us
**RCP 2 Verification of Licensure in Other States Supplemental Form**

**VERIFICATION OF OTHER STATE LICENSES**

**Part 1**

**APPLICANT:** Complete and sign Part 1 and send a copy of this form to each state board that ever issued you a license/certificate/registration to practice as a Respiratory Therapist. Also send use this form to send to each state board, including Maryland, that ever issued you a license/certification/registration to practice as ANY other health care practitioner. Please copy this form if you need to send it to more than one state board.

| License Type: | __________________________________________ |
| State of Licensure: | ________________________________________ |
| License Number: | __________________________________________ |
| Date: | __________________________________________ |
| Expiration Date: | __________________________________________ |

**Name:** _______________________________________________________________________________________________________________

(Print) Last (Generational Indicator, Jr., III) First Middle Maiden

Social Security No.: __________________________________ Date of Birth: ________/_______/_______

Professional School of Graduation: ____________________________ Year: ____________________________

Signature: __________________________________ Date: ____________________________

**Part 2**

**AUTHORIZED OFFICIAL OF STATE MEDICAL BOARD:** Please certify the following information regarding the above-listed individual and send this form directly to the Maryland Board of Physicians at the above address.

<table>
<thead>
<tr>
<th>License number</th>
<th>Date Issued</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

Is/was the license in good standing? ☐ Yes ☐ No

If not in good standing is/was it: ☐ reprimanded ☐ suspended ☐ revoked ☐ surrendered

Was the license administratively revoked, suspended, or surrendered because the licensee did not renew? ☐ Yes ☐ No

If yes, please explain: _______________________________________________________________________________________

________________________________________________________________________________________________________

Other Derogatory Information or Pending Charges: ___________________________________________________________________

________________________________________________________________________________________________

Printed Name of Authorized Official ____________________________ Direct Telephone Number ____________________________

Title of Authorized Official ____________________________ Printed Name of State ____________________________

Signature of Authorized Official ____________________________ Date ____________________________

State Board Seal