



RESPIRATORY CARE ADVISORY BOARD

New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION

Physical Address: 2550 Cerrillos Rd ▪ Santa Fe, New Mexico 87504
 Mailing Address: P. O. Box 25101 ▪ Santa Fe, New Mexico 87504
 (505) 476-4965 ▪ Fax (505) 476-4645 ▪ www.RLD.state.nm.us

RESPIRATORY CARE PRACTITIONER APPLICATION

Application fees are non-refundable.

All license information provided is public information.

Please print out the form and print legibly in Black or Blue ink. Attach additional pages if more space is required to respond to questions below.

*** Required Fields**

APPLICATION CHECKLIST—*Submit the following items and documentation with this application.*

- Completed and Signed Application (16.23.4.8 NMAC)
- \$150 Application Fee paid by check or money order. (16.23.2.8 NMAC)
- Current 2x2 original color Passport type photograph (16.23.4.8 NMAC)
- Copy of official transcript or Copy of Respiratory Care program Completion Certificate or Diploma (16.23.4.8 NMAC)
- Copy of National Boards for Respiratory Care (NBRC) certificate (CRT or RRT), **OR** Copy of applicants NBRC identification card (CRT or RRT), **OR** Copy of the exam results showing successful passing of the NBRC (CRT or RRT) Examination (16.23.4.8 NMAC)
- Copies of other state professional licenses, if applicable (16.23.4.8 NMAC)
- Verification of licensure forms sent directly from other state boards, if applicable (16.23.4.8 NMAC)
- Résumé with employment information encompassing five years prior to the application (16.23.4.8 NMAC)
- 20 hours of CE within the last year (if applicable)

Applicants applying for licensure who cannot provide proof of having been working in the field of respiratory care within the immediate preceding five years prior to licensure application in New Mexico must provide proof of having successfully passed the exam for CRT or RRT administered by the NBRC and taken within the year of licensure application in New Mexico In Lieu of experience or successfully passing the NBRC with in the year of licensures the licensee may submit 20 hours of required continuing education take within the year of licensure application. (16.23.3.10 NMAC)

Explanations for any yes answers in the **PERSONAL HISTORY** section of this application

I am applying for (check one) CRT RRT

| | | | | |
|---|--|------------------------|---------------------|-----------------|
| *Last name: | | *First name: | | Middle initial: |
| *Social Security Number: | | *Date of birth: | Place of birth: | |
| Maiden or previous name(s): | | | | |
| *Mailing address: | | | *Home phone: | |
| *City: | | *State: | *Zip code: | |
| Street address: (if different from mailing) | | | Work phone: | |
| City: | | State: | Zip code: | |
| *Email: | | | | |
| All communications (including renewal notices) will be sent out to this email address | | | | |
| Respiratory Therapy Education Program: | | | | |
| Date program diploma awarded: | | | | |
| NBRC Certification Award Dates: CRT | | RRT | | |
| List other NBRC Certification: | | | | |
| Employer: | | Department: | | |
| Type: <input type="checkbox"/> Hospital <input type="checkbox"/> PRN <input type="checkbox"/> Home care <input type="checkbox"/> LTC <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Self-employed <input type="checkbox"/> Other: | | | | |
| Street Address: | | City: | State: | Zip: |

EDUCATION— In chronological order beginning with high school, list all schools and training programs attended, including accredited respiratory care training programs, colleges, universities, etc.

| School Name | Complete address including zip code | Dates of attendance | Date graduated | Degree/Major |
|-------------|-------------------------------------|---------------------|----------------|--------------|
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LICENSURE HISTORY— List all states, including New Mexico, where you have ever held a license, whether current or expired. *Applicant is responsible for sending Verification of Licensure Request Form to each state and must inquire with each state board to find out the process to request the information and if a fee is required.*

| State | Status of License—active, inactive, expired, lapsed, suspended, or revoked. | Issue Date | Expiration Date | License Type |
|-------|---|------------|-----------------|--------------|
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PERSONAL HISTORY

If you answer yes to any of the following questions you must attach an explanation and supporting documents, such as court orders, board orders, stipulations, and/or proof of compliance.

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Have you had a license to practice a profession revoked, suspended, or otherwise sanctioned? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Have you had a license to practice a profession denied? If so, where and why? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Have you had any type of disciplinary action with regard to sitting for a licensing examination? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Have you been refused a license renewal pursuant to a disciplinary proceeding? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Have you knowingly failed to renew a license during an investigation or disciplinary action? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. To the best of your knowledge, is there any disciplinary action pending against you by any licensing board or professional society or association? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Have you ever failed to complete the terms of a disciplinary finding, agreement, or final order? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you ever allowed your license to expire in a state where you have still not completed the terms of a disciplinary action's settlement agreement or final order? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Have you ever received a deferred prosecution or judgment or been convicted of or pled guilty or <i>nolo contendere</i> to felony or misdemeanor (not including traffic violations) in any state, territory, jurisdiction, or district of the United States or a foreign country? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Are you currently engaged in the illegal use of a controlled substance? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. If you answered yes to question 11, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaging in the illegal use of controlled substances? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Do you have a medical condition that in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. If you answered yes to question 14, does your use of chemical substance(s) or medications in any way impair or limit your ability to practice respiratory care with reasonable skill and safety? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Are you currently more than a month in arrears in court-ordered child support payments in New Mexico or in any other state? |

CERTIFICATION

I, the undersigned, do hereby certify that this application contains no willful misrepresentation and that the information given by me is true and complete to the best of my knowledge and belief.

I further certify that upon licensure, I will familiarize myself with the rules and regulations governing respiratory care practitioners in New Mexico and I fully understand that I bind myself to be governed by them should I be approved for licensure.

APPLICANT'S SIGNATURE:

DATE:

Staple passport type photo here.