

# STATE OF MAINE

## STATE BOARD OF RESPIRATORY CARE PRACTITIONERS

### APPLICATION FOR LICENSURE

- RESPIRATORY CARE THERAPIST
- RESPIRATORY CARE TECHNICIAN
- TEMPORARY RESPIRATORY CARE TECHNICIAN
  - RESPIRATORY CARE TRAINEE



Department of Professional and Financial Regulation

Office of Licensing and Registration  
35 State House Station  
Augusta, ME 04333-0035

Office Telephone: (207) 624-8600 or (207) 624-8620  
TTY/HEARING IMPAIRED (207) 624-8563  
Office located at: 122 Northern Avenue, Gardiner, Maine

## APPLICATION INSTRUCTIONS

The Board of Respiratory Care Practitioners requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

Listed below are the requirements for licensure as a respiratory care practitioner in Maine. This is provided for informational purposes only. For details you must refer to the Laws and Rules. Payment of fees may be made in the form of a check payable to Treasurer, State of Maine, VISA, or MasterCard.

### **FOR: THERAPISTS AND TECHNICIANS**

- Application fee: \$25.00
- License fee: \$135.00, (\$67.50 after May 1st of odd numbered years)
- Completed reference form (Attachment "B")
- Verification of licensure from every state that you hold or have ever held a license in (Attachment "C")
- Notarized copy of NBRC card or Notarized Proof of successful completion of the NBRC exam
- Written confirmation of applicant's credential from the NBRC. You can reach the NBRC at: 8310 Nieman Road, Lenexa, KS 66214-1579, Telephone # (913) 599-4200. You need to inform the NBRC to send the verification to you.
- Payment of a separate \$8.00 fee for a criminal records (SBI) check. Make check payable to: Maine State Treasurer

### **FOR: TEMPORARY TECHNICIANS**

- Application fee: \$25.00
- License fee: \$70.00
- Completed reference form (Attachment "B")
- Completed supervisor's affidavit (Attachment "A")
- Note: An affidavit form is required for each employer**
- Notarized proof of graduation from an AMA accredited school for respiratory care
- Letter from school confirming graduation from a respiratory care program and level of program
- Payment of a separate \$8.00 fee for a criminal records (SBI) check. Make check payable to: Maine State Treasurer

### **FOR: TRAINEE**

- Application fee \$25.00
- Completed supervisor's affidavit form (Attachment "A")
- Verification of enrollment in a respiratory care program. As verification of enrollment, the Board will accept the following:
  - A. Notarized copy of certificate of enrollment in an accredited respiratory care program, or
  - B. Original or notarized copies of official letter from the accredited respiratory care program indicating that the applicant is enrolled at the time of application
- Payment of a separate \$8.00 fee for a criminal records (SBI) check. Make check payable to: Maine State Treasurer



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Direct Tel: (207) 624-8600 Receptionist: (207) 624-8603  
 FAX: (207) 624-8637 TTY/Hearing Impaired: (207) 624-8563

ANGUS S. KING, JR.  
 GOVERNOR

ANNE L. HEAD  
 DIRECTOR

Email: [linda.l.duffy@state.me.us](mailto:linda.l.duffy@state.me.us)

**APPLICATION FORM**

PLEASE CHECK APPROPRIATE BOX:

- Respiratory Care Technician                       Respiratory Care Therapist
- Temporary Respiratory Care Technician                       Respiratory Care Trainee

*The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section 405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.*

PERSONAL INFORMATION

<b>Name:</b>		
<b>Mailing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>	<b>Telephone #:</b> (____) _____ - _____	
<b>Social Security #:</b> (____)-(____)-(____)		<b>Date of Birth:</b> _____

EDUCATION

Name of Accredited School: \_\_\_\_\_

Diploma/Degree Awarded: \_\_\_\_\_ Date Degree Awarded: \_\_\_\_\_  
 Month Year

**FOR TRAINEES ONLY**

Name of Accredited School:

\_\_\_\_\_

Enrollment Date: \_\_\_\_\_

Expected Date of Graduation: \_\_\_\_\_

Month                      Year

**FOR TEMPORARY TECHNICIANS AND TRAINEES ONLY**

Name of Supervisor:

License #:

Printed Name of Supervisor:

**SUPERVISOR MUST BE A PERMANENT LICENSED CARE PRACTITIONER AND MUST COMPLETE THE SUPERVISOR'S AFFIDAVIT FORM. RETURN THIS FORM WITH YOUR APPLICATION**

**EMPLOYMENT**

Facility

Address

Dates

Position

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR ALL CATAGORIES**

**ALL APPLICANTS MUST ANSWER EVERY QUESTION WITH A YES OR NO, IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER:**

Have you ever been credentialed or licensed in another State or Territory?                       Yes  No

If credentialed or licensed in more than one State, please list each state separately.

State: \_\_\_\_\_ Registration # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Expiration date: \_\_\_\_\_

State: \_\_\_\_\_ Registration # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Expiration date: \_\_\_\_\_

State: \_\_\_\_\_ Registration # \_\_\_\_\_ Date Issued: \_\_\_\_\_ Expiration date: \_\_\_\_\_

1. Has any State Board governing the practice of respiratory care denied your application for examination or license?                       Yes  No

2. Has your credential or license ever been suspended or revoked by any State?                       Yes  No

3. Have you ever been convicted of a crime, other than a minor traffic violation?                       Yes  No  
If yes, please submit copy of the court judgment and decision and a detailed explanation of the crime convicted.

4. Do you now hold any trainee permit or temporary license with the Maine Board of Respiratory Therapist?                       Yes  No

***I AFFIRM UNDER PENALTIES OF PERJURY AND SUBJECT TO THE DISCIPLINARY LAWS AND RULES OF THE BOARD THAT ALL INFORMATION REQUESTED IN THIS APPLICATION FORM HAS BEEN ANSWERED AND THAT ALL ANSWERS ARE ACCURATE AND TRUTHFUL.***

PRINTED OR TYPED NAME OF APPLICANT: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

DATE: \_\_\_\_\_

**NOTE: YOU MUST INSURE THAT ALL MATERIALS ARE COMPLETE AND ALL APPLICATION REQUIREMENTS MUST BE SUBMITTED WITH THE FILING OF THE APPLICATION. INCOMPLETE APPLICATIONS WILL BE RETURNED.**



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**SUPERVISOR'S AFFIDAVIT**  
ATTACHMENT "A"

**REQUIRED FOR:** (1) LICENSURE AS A TEMPORARY TECHNICIAN, OR  
 (2) REGISTRATION AS A RESPIRATORY CARE TRAINEE

**NOTE:** TO BE COMPLETED BY A MAINE LICENSED RESPIRATORY CARE PRACTITIONER WHO WILL SUPERVISE THIS APPLICANT. THE COMPLETED FORM MUST BE RETURNED DIRECTLY TO THE APPLICANT TO BE SUBMITTED WITH HIS/HER APPLICATION.

<b>Name of Applicant:</b>		
<b>Name of Supervisor:</b>		
<b>Supervisor's License #:</b>	<b>Level:</b>	
<b>Facility:</b>	<b>Telephone #: (____) _____ - _____</b>	
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
Applicant Signature:		Date:
Printed Signature:		

=====

I HEREBY CERTIFY THAT THE ABOVE-NAMED APPLICANT WILL BE UNDER MY SUPERVISED RESPIRATORY CARE PRACTICE FOR THE PERIOD OF \_\_\_\_\_ TO \_\_\_\_\_. I UNDERSTAND THAT THE BOARD MAY REQUEST INFORMATION CONCERNING WORK PERFORMANCE BY THE APPLICANT UNDER MY SUPERVISION, OR INSPECT THE "ORIENTATION CHECKLIST" AS SPECIFIED UNDER 32 M.R.S.A. SECTION 9707 (FOR TEMPORARY TECHNICIAN LICENSE) OR SECTION 9707-A (FOR RESPIRATORY CARE TRAINEE REGISTRATION).

Supervisor's Signature:	License #:
Printed or Typed Name of Supervisor:	Date:



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**PROFESSIONAL REFERENCE FORM- Attachment "B"**

Please Complete This Form and Return Directly to Applicant

<b>Name of Applicant:</b>		
<b>Mailing Address of Applicant:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>	<b>Telephone #: ( ) -</b>	
<b>Social Security #: ( )-( )-( )</b>		<b>Date of Birth:</b>
<b>In what professional capacity do you know the applicant?</b>		
<b>How long have you known the applicant?</b>		
<b>Are you related to the applicant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, how?</b> _____		
<b>Please give a brief statement of your knowledge of the applicant's ethical practice of respiratory care:</b>		
<hr/> <hr/> <hr/> <hr/>		
<b>Signed:</b> _____		<b>Date:</b> _____
<b>Printed name:</b> _____		<b>Title:</b> _____
<b>Mailing Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>



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**VERIFICATION OF LICENSURE**  
**(Attachment "C")**

**INSTRUCTIONS:** THE APPLICANT LISTED BELOW IS APPLYING FOR LICENSURE TO PRACTICE RESPIRATORY CARE IN THE STATE OF MAINE. THE MAINE BOARD OF RESPIRATORY CARE PRACTITIONERS REQUESTS WRITTEN VERIFICATION FROM EACH STATE WHERE THE APPLICANT HOLDS ANY CERTIFICATION LICENSURE OR OTHER CREDENTIAL. THIS IS YOUR AUTHORITY TO RELEASE ANY INFORMATION IN YOUR FILES, FAVORABLE OR OTHERWISE.

**PLEASE MAIL THIS VERIFICATION DIRECTLY TO THE APPLICANT.**

**THIS SECTION TO BE COMPLETED BY THE APPLICANT AND FORWARDED TO THE BOARD THAT ISSUED THE LICENSE.**

<i>Name of Applicant:</i>		
<i>Mailing Address of Applicant:</i>		
<i>City:</i>	<i>State:</i>	<i>Zip Code:</i>
<i>License #</i>	<i>State</i>	Issue Date
Applicant Signature:		

**THIS SECTION TO BE COMPLETED BY THE STATE LICENSING BOARD WHERE APPLICANT HOLDS OR HAS HELD LICENSURE AND FORWARDED BACK TO THE APPLICANT.**

TYPE OF LICENSE HELD BY APPLICANT  THERAPIST  TECHNICIAN  
 IS APPLICANT CURRENTLY LICENSED?  YES  NO

IF NOT CURRENTLY LICENSED, WHEN DID LICENSE EXPIRE?  
 LICENSE #: \_\_\_\_\_ ORIGINAL ISSUE DATE: \_\_\_\_\_

IS THE APPLICANT CONSIDERED A RESPIRATORY THERAPIST/TECHNICIAN IS GOOD  
 STANDING IN YOUR STATE?  YES  NO IF NO, PLEASE EXPLAIN:  
 HAS THERE BEEN ANY COMPLAINTS FILED AGAINST THIS APPLICANT RESULTING IN  
 DISCIPLINARY ACTION TAKEN?  YES  NO  
 IF YES, PLEASE EXPLAIN? \_\_\_\_\_

State Officials Signature:	Date:
Printed or Typed Name:	Title:
Name of State Board:	Phone Number:



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TO: PROSPECTIVE APPLICANT  
FROM: OFFICE OF LICENSING & REGISTRATION  
RE: CRIMINAL RECORDS CHECK

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for all applicants.

**CRIMINAL HISTORY RECORDS CHECK PROCEDURE**

Attached is a form addressed to the Maine Department of Public Safety, Bureau of Identification. Please complete the applicant information section of the enclosed form and send it to the appropriate licensing board with your completed application and supporting documentation as may be necessary. **Do not send the request directly to the Department of Public Safety.**

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identifications to charge a fee to government organizations for services provided. Therefore, as of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety.

You must provide a separate check in the amount of \$8.00, made payable to Maine State Treasurer, as payment for your criminal history record check in addition to the licensing fees presently required. Please note that the criminal history record will be returned to the licensing board, not the applicant.

Please contact the board clerk at the number below if you have questions or need assistance.

**(Clerk Name and Phone Number) Linda Duffy  
(207) 624-8600**



PRINTED ON RECYCLED PAPER

PHONE: (207)624-8600  
(Office Phone)

FAX: (207)624-8637

(207)624-8653 (TTY/HEARING IMPAIRED)  
OFFICES LOCATED AT: 122 NORTHERN AVENUE,  
GARDINER, MAINE





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**AUTHORIZATION OF CREDIT CARD PAYMENT**

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

<b>Name:</b> (applicant fees being paid for)		
<b>Mailing Address:</b> (applicant fees being paid for)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>		<b>Telephone #:</b> ( ) -
<b>Name of cardholder:</b> (if other than applicant)		
<b>Mailing Address:</b> (if other than applicant)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

Visa     MasterCard \_\_\_\_\_

Expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of: \$ \_\_\_\_\_  
 Card number

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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