

# STATE OF MAINE

## **STATE BOARD OF RESPIRATORY CARE PRACTITIONERS APPLICATION FOR ASSOCIATE PERMIT**



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  
HEARING IMPAIRED (207) 624-8563

Office located at: 122 Northern Avenue, Gardiner, Maine

Last Revised: 4/2000

**APPLICATION INSTRUCTIONS  
FOR AN ASSOCIATE PERMIT**

***If you are coming from another state and plan to practice in Maine in association with a respiratory care practitioner licensed in Maine for no more than 30 days in a calendar year, you must apply for an receive an Associate permit before you can start working.***

Completed applications must be submitted with all of the supporting materials, including fees. Incomplete applications will be returned. Payments may be made in the form of a check payable to Treasurer, State of Maine, VISA, or MasterCard.

If an applicant is licensed in another state the following must be submitted:

- Application
- Permit fee \$10.00
- Verification of license in good standing from another state that has licensure requirements equivalent to the requirements of this chapter.  
**(Attachment "C")**
- At the time of application, the associate must report all of the dates and locations that the respiratory services will be performed in Maine, which may not exceed 30 days in a calendar year.

If an applicant is certified or registered by the National Board of Respiratory Care and resides in a non-licensure state the following must be submitted:

- Application
- Permit fee \$10.00
- Verification of being certified or registered by the National Board of Respiratory Care
- At the time of application, the associate must report all of the dates and locations that the respiratory services will be performed in Maine, which may not exceed 30 days in a calendar year.



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 DEPARTMENT OF PROFESSIONAL  
 AND FINANCIAL REGULATION  
 BOARD OF RESPIRATORY CARE PRACTITIONERS  
 35 STATE HOUSE STATION  
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ANGUS S. KING, JR.  
 GOVERNOR

ANNE L. HEAD  
 DIRECTOR

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

***Associate Permit Application Form***

<b>Applicant Name:</b>		
<b>Applicant 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>
<b>Applicant Place of Employment: Name of Facility</b>		
<b>Mailing Address of Facility:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>	<b>Telephone #: (____) _____ - _____</b>	
<b>Date of Employment under the associate permit</b>		<b>From: _____ To: _____</b>
<b>Name of Maine licensed respiratory care practitioner who you will be working with:</b>		
<b>License #:</b>	<b>Telephone #: (____) _____ - _____</b>	

<b>Applicants Place of Employment:(Name of Facility)</b>		
<b>Mailing Address of Facility:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>	<b>Telephone #: (_____) _____ - _____</b>	
<b>Date of Employment under the associate permit</b>	<b>From: _____ To: _____</b>	
<b>Name of Maine licensed respiratory care practitioner who you will be working with:</b>		
<b>License #:</b>	<b>Telephone #: (_____) _____ - _____</b>	

**PLEASE ANSWER ALL QUESTIONS WITH A YES OR NO, IF YES, PLEASE PROVIDE A DETAILED EXPLANATION ON A SEPARATE SHEET OF PAPER:**

Are you currently or 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.  
(If you are licensed in additional States, please list on a separate piece of paper)

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

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

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

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

Do you currently have a complaint or an adverse action pending by any State Board governing the practice of Respiratory Care?  Yes  No

Has your credentials or license ever been suspended or revoked by any State?  Yes  No

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.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



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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 CREDENTIALS. 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.**

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

**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: \_\_\_\_\_

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VERIFICATION OF LICENSURE  
(Attachment "C")

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: \_\_\_\_\_

<b>State Official Signature:</b>
<b>Date:</b>
<b>Printed Name:</b>
<b>Title:</b>
<b>Name or Phone Number of State Board:</b>



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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 \_\_\_\_\_ **Card number**

**Expiration date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **in the amount of: \$** \_\_\_\_\_

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

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



PRINTED ON RECYCLED PAPER  
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