South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
110 Centerview Dr • Columbia • SC• 29210
P.O. Box 11289 • Columbia • SC• 29211
Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515
www.llronline.com/POL/Medical/

REQUIREMENTS FOR A LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER

READ REQUIREMENTS CAREFULLY BEFORE COMPLETING APPLICATION.

I. GENERAL INFORMATION

The term Respiratory Care Practitioner encompasses both respiratory therapists and respiratory therapy technicians. Section 40-47-510 (5)

II. REQUIREMENTS FOR LICENSURE

In order to qualify for a license as a respiratory care practitioner the applicant must file a written application on forms provided by the Board and must show that he/she meets the following requirements (Section 40-47-600):
(a) good moral character;
(b) passage of the entry level examination given by the National Board for Respiratory Care, Inc., or other examination that may be approved.

III. FEES (APPLICATION FEE IS NON-REFUNDABLE)

The application fee for permanent licensure is $120.

IV. APPLICATION FORM

The application form is self-explanatory. It sets forth the required supporting documents and/or information that must be submitted with your application. The Board will not consider an applicant for licensure until a complete application along with appropriate fee is submitted.

An application will be considered as incomplete until all of the following information is submitted:
(a) all questions on the application answered fully;

(b) all supporting documents and/or information required by application form received;

(c) National Board examination results received;

(d) State licenses/certificates verified;

(e) application fee submitted.

V. CRIMINAL BACKGROUND CHECK– See enclosed procedures

VI. PROCESSING TIME

Applications having all information with no identifiable problems will be expeditiously processed. Incomplete applications or problematic applications will require additional processing time.

When applying for licensure, If you do not know where you will be working in South Carolina and/or who the medical director is, please mark "unknown at this time in that space. Please remember, before you can begin working in South Carolina, you must notify the Board in writing of where you will be working, in South Carolina, and who the medical director will be.

POLICY OF THE BOARD REQUIRES INDIVIDUALS WHO HAVE NOT ACTIVELY PRACTICED RESPIRATORY CARE FOR FIVE (5) YEARS OR MORE TO TAKE AND PASS THE NBRC-ENTRY LEVEL EXAMINATION. PROOF OF PASSAGE MUST BE PROVIDED TO THE BOARD BEFORE YOUR LICENSE WILL BE ISSUED.

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Criminal Background Check (CBC) Instruction Sheet

An applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in Section 40-47-36 of the Medical Practice Act.

This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI). These services are provided by IdentoGO Centers and are operated by MorphoTrust USA.

Residents of South Carolina should go online to schedule for fingerprinting services: http://www.identogo.com/FP/SouthCarolina.aspx or call (866) 254-2366 for assistance in scheduling. Scheduling services will provide detailed information of forms of identification that will be required.

If you are a non-resident of South Carolina and do not reside in an area near South Carolina, please follow the **Non-Resident Card Scan Processing Procedures** below.

Non-Resident Card Scan Processing Procedures

For applicants that reside out of South Carolina who wish to use the IdentoGO/Morpho Trust USA Centers, you may use these centers that are located in South Carolina only. If an applicant does not reside near South Carolina, they must complete and submit the fingerprint cards by following the directions below. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. The section below details the procedures for submitting fingerprints to the MorphoTrust card scan department. Applicant should contact IdentoGO/MorphoTrust (866-254-2366) to verify the current fee to submit.

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards.
- Fingerprints may be submitted on FBI applicant cards. The applicant may call or email the Medical Board to have the FBI applicant cards mailed to them. Phone: 803-896-4500 or email: **Medboard@llr.sc.gov.** Due to agency specific information, MorphoTrust USA does not provide fingerprint cards to applicants.
- Applicant should ensure the fingerprint cards are completely filled out. Required information includes:
  - ORI Number: **SC920110Z**
  - Full Name
  - Home Address
  - Place of Birth (State or Country Only)
  - Citizenship
  - Social Security Number
  - Date of Birth
  - Sex, Height, Weight, Hair Color and Eye Color
  - Reason fingerprinted
- Mail the fully completed card and applicable fee (Include full name of applicant on the check) to:

MORPHOTRUST USA
ATTN: SC Card Scan
3051 HOLLIS DR SUITE 310
Springfield, IL 62704

Follow-up calls and questions on the processing of a fingerprint card should be made directly to IdentoGO/MorphoTrust at (866) 254-2366 and speak to a customer service representative.

DO NOT return fingerprint card or fingerprint processing fee in with your application or to the Board of Medical Examiners. This will delay the processing of your application.

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Application to Practice as a Respiratory Care Practitioner

Include with your application:

- Check or money order in the amount of $120 made payable to LLR-Board of Medical Examiners Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, **may** be assessed on all returned funds.
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- Legal documentation for name change
- Copy of CRT or RRT National Board Certificate or examination results
- Physician Sponsor Statement, if performing home care duties
- Copy of Respiratory Care Diploma or have an official transcript sent to the Board

Have submitted directly to the Board office address above from the issuing agent:

- License Verification from each state medical board that you are currently or have ever been licensed in.
- 3 Letters of Recommendation
- Criminal Background Check (CBC) – See CBC Instruction Sheet

Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

I. APPLICANT INFORMATION:

Last Name:_____First:_____Middle:_____Suffix:_____

Have you ever legally changed your name? ☐ Yes ☐ No Maiden Name:_____
If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: _____City:_____State:_____ Zip:_____District:_____
Congressional District (SC Residents Only)

Mailing Address: _____City:_____State:____Zip:_____
(If different than above)

Phone: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____

Place of Birth (City, State or Country): _____

Race: _____ Gender: ☐ Female ☐ Male
(for statistical purposes only)

BUSINESS INFORMATION:

If known, otherwise mark "unknown at this time"

SC Medical Director:_____

Business Address: _____

Business Phone: _____ Business Email Address: _____

Name: _____

1. Do you plan to care for cardio-pulmonary patients in a home care setting? YES ☐ NO ☐

   If yes, you must attach a statement signed by your physician sponsor detailing the duties that you will perform and the type of supervision you will receive in performing these duties.

II. EDUCATION INFORMATION

List in chronological order from date of graduation all professional education. Attach a copy of your Respiratory Care Diploma or have an official transcript sent directly to the Board from your school. If additional space is needed, you may attach an additional sheet.

School	LOCATION (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Graduation/Program Completed?	Degree Earned

III. RECORD OF EXAMINATION

Complete the requested information below if any national or state licensure examination was taken for respiratory care. A copy of you CRT or RRT National Board Certificate or examination results must be included with this application. Verification directly from National Board for Respiratory Care, Inc. (NBRC) may be required if appropriate documentation is not provided. Provide a written explanation if certificate is not attached.

Name of Examination (Include level, if applicable)	Registry/Certification Number (if applicable)	Location	Date of Exam	Passed/Failed Score
CRT				
RRT				

IV. RECORD OF LICENSURE

List all states in which you have been licensed in for any medical profession; regardless of status: Active, Inactive, Expired, Training etc. You will need to contact each State Board and request a License Verification to be mailed directly to the Medical Board at the above listed address. We provide a License Verification Form as a courtesy; however, we will accept a state board issued form. Attach additional sheet if needed.

State/Jurisdiction	License No.

State/Jurisdiction	License No.

State/Jurisdiction	License No.

Name: _____

V. MEDICAL PRACTICE EMPLOYMENT HISTORY

List all employment relevant to training and/or work experience in respiratory for the past five (5) years. If you have never been employed in the profession you are applying for, insert N/A. Attach an additional sheet if needed.

FROM Month / Yr	TO Month / Yr	EMPLOYER NAME	OFFICE ADDRESS	TYPE OF PRACTICE

VI. PERSONAL HISTORY INFORMATION

If you answer yes to any of the below questions, you must attach a full written explanation.

1. Has your Respiratory Care Practitioner certificate/license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a medical licensing board or other entity? YES ☐ NO ☐

2. Have you ever had an application to practice as a Respiratory Care Practitioner denied or refused by another medical licensing board or other entity? YES ☐ NO ☐

3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way? YES ☐ NO ☐

4. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action? YES ☐ NO ☐

5. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? YES ☐ NO ☐

6. Are you currently being treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? YES ☐ NO ☐

7. Do you currently have any mental illness (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) or any physical illness or condition that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? YES ☐ NO ☐

8. Is your ability to practice as a Respiratory Care Practitioner currently impaired by any physical or mental illness or by the use of alcohol or drugs? YES ☐ NO ☐

9. Within the past two (2) years, has your ability to practice as a Respiratory Care Practitioner been impaired by any physical or mental illness or by the use of alcohol and/or drugs? YES ☐ NO ☐

Name: _____

10. Have you ever discontinued the practice as a Respiratory Care Practitioner for any reason for three consecutive months or more? YES ☐ NO ☐

11. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license? YES ☐ NO ☐

12. Have you ever been discharged involuntarily from employment? If so, give full details. YES ☐ NO ☐

13. Have you ever been convicted, pled guilty or pled nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? YES ☐ NO ☐

VII. LETTERS OF RECOMMENDATION

The references listed must be more than a casual acquaintance and of a substantial duration but does not need to be a respiratory care practitioner. Please have your references fill out the enclosed Reference for Respiratory Care Practitioner Applicant form and forward to the Board office. There are electronic PDF versions on the website that you may email and have the reference fill out and mail in on your behalf.

Reference 1.

Name: _____ Phone: _____

Address: _____
Street, City, State, Zip

Reference 2.

Name: _____ Phone: _____

Address: _____
Street, City, State, Zip

Reference 3.

Name: _____ Phone: _____

Address: _____
Street, City, State, Zip

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

VIII. CERTIFYING STATEMENT

I, _____ being duly sworn, depose and say that I am the person described and identified, and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as a Respiratory Care Practitioner in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agents or representatives and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice as a Respiratory Care Practitioner in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

_____
Signature of Applicant

_____
Print Name of Applicant

Subscribed and sworn to before me this _____ day

of _____20_____.

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____

Tape a recent 2 x 2
Passport Photo
(less than 6 months old)

(Notary Seal)

NOTE:

Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, license verifications, etc.

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of_____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other:_____Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number:_____ I-94 Number: _____

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

_____
Signature of Affiant

SWORN to before me this_____day of_____, 20_____

_____
Notary Signature

_____
Print Name

Notary Public for _____

My Commission Expires: _____

Rev: 02-02-2015

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)

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REFERENCE FOR RESPIRATORY CARE PRACTITIONER APPLICANT

- Make copies or provide a link of this form to each reference.
- Individuals giving a reference should know you in a professional capacity. They cannot be related by blood or marriage.

Applicant's Name: _____

Dates of Association: _____ Relation to Applicant: _____

Describe the applicant's moral character and fitness (attach a separate sheet of paper if necessary)

Moral Character: _____

_____

_____

_____

_____

Professional Competence: _____

_____

_____

_____

_____

Interpersonal Relations with Others: _____

_____

_____

_____

_____

_____ _____
Signature Date

_____ _____
Print Name Daytime Phone Number

_____
Street Address City State Zip

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RESPIRATORY CARE PRACTITIONER VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever have been licensed to practice as a respiratory care practitioner. You may want to contact each state to see if a fee is required.

In applying for a license to practice as a respiratory care practitioner in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. The Board will accept a state board issued verification. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature: _____

Name: _____

Address: _____

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners at the above address. The Board will accept a state issued verification.

Name of Licensee: _____

State of: _____ Type of License: _____ License number: _____

Date issued: _____ Expiration Date: _____

Is license current ☐ Yes ☐ No If no, why not? _____

Has license been suspended, revoked, or restricted? ☐ Yes ☐ No If yes, why? _____

Comments/Derogatory Information, if any: _____

_____

_____

Date: _____

Signature: _____

Print name: _____

Board Seal

Title: _____

Board: _____