SC Department of Labor, Licensing and Regulation
Board of Medical Examiners
Post Office Box 11289
Columbia, SC 29211
(803) 896-4500
(803) 896-4515 Fax

REQUIREMENTS FOR AN "UPDATE" 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. APPLICATION FORM

III. FEES (APPLICATION FEE IS NON-REFUNDABLE)

The application fee for an "Update" licensure is $80.

IV. COPY OF CRT OR RRT FROM THE NATIONAL BOARD OF RESPIRATORY CARE

V. COPY OF DIPLOMA FROM RESPIRATORY PROGRAM (if applicable)

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.

S.C. Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive
Post Office Box 11289
Columbia SC 29211
(803) 896-4500

UPDATE
Fee $80

APPLICATION FOR A LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER

IMPORTANT: Read the enclosed requirements carefully before completing application. Appropriate fee must accompany application; **application fee is non-refundable.** *The application form itself is a public document obtainable under the Freedom of Information Act.*

I hereby make application for a license to practice as a respiratory care practitioner in the State of South Carolina and submit the following statements of facts with the required supporting documents:

(Please type or print clearly)

Applicant's Name: _____
Last First Middle

Home Address: _____

_____
City State Zip

Home Phone: ( )_____

S.C. Medical Director: _____

Place of Employment in South Carolina: _____

_____
Street

_____
City State Zip

Business Phone ( )_____

The SSN is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Date Bank (HIPDB) and the National Practitioner DataBank (NPDB), among other things.
(Revised 7/10/12)

I. PERSONAL DATA

Answer Yes or No

1. Has your Respiratory Care Practitioner certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? ☐ **Yes** ☐ **No**

2. Have you ever had an application to practice as a Respiratory Care Practitioner denied or refused by another licensing board or entity? ☐ **Yes** ☐ **No**

3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? ☐ **Yes** ☐ **No**

4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? ☐ **Yes** ☐ **No**

5. Are you currently under any investigation or the subject of pending disciplinary action by any licensing board or other entity? ☐ **Yes** ☐ **No**

6. Is your Respiratory Care Practitioner's certificate/license currently restricted in any way by any medical licensing board, health care facility or other entity? ☐ **Yes** ☐ **No**

7. Currently or within the last ten years, have you been 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**

8. Has your ability to practice as a Respiratory Care Practitioner ever been impaired by any physical or mental illness or by the use of alcohol or drugs? ☐ **Yes** ☐ **No**

9. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? ☐ **Yes** ☐ **No**

10. Have you ever discontinued practicing as a Respiratory Care Practitioner for any reason for one month or more? ☐ **Yes** ☐ **No**

11. Have you ever been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state or local law (other than a minor traffic violation)? ☐ **Yes** ☐ **No**

12. Have you ever been known by any other name or surname? ☐ **Yes** ☐ **No**

13. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license? ☐ **Yes** ☐ **No**

14. Have you ever been discharged involuntarily from employment? If so, give full details. ☐ **Yes** ☐ **No**

NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.

II. EDUCATION

Attach copies of diplomas, degrees and certificates of training.

School attended Name and Address	**Dates Attended From (Mo./Yr.) to (Mo./Yr.)**	**Diploma or Degree Received**
High School:		
College:		
Respiratory Therapy Training:		
Graduate School:		

III. PROFESSIONAL INFORMATION

List all states in which you are licensed or certified to practice as a respiratory care practitioner (active/inactive).

State	**License/Certificate Number**	**Date Issued**	**Basis of Licensure/Certification**	**Status (Active/Inactive)**

III. PROFESSIONAL INFORMATION
(Continued)

1. Have you taken the entry level or higher level National Board for Respiratory Care, Inc. Examination? _____If so, please specify date and examination taken and whether you passed or failed. _____If registered, give your registry number_____.
A copy of your CRTT or RRT National Board certificate or examination results must be included with this application. Verification directly from NBRC may be required if appropriate documentation is not provided. Provide written explanation if certificate is not attached.

2. Have you ever taken any other state or national examination(s) in respiratory therapy?_____
If so, give the date(s), location and name of examination(s) taken, and indicate whether you passed or failed.

3. Do you plan to care for cardio-pulmonary patients in a home care setting? _____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.

IV. EMPLOYMENT HISTORY

In chronological order (most recent first), list all employment relevant to training and/or work experience in respiratory therapy since graduating from your respiratory care program.

Place of Employment (Name of Company, City and State)	**Dates of Employment**	**Title and Job Description**

(Attach additional sheet of paper is needed)

V. AFFIDAVIT

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character 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 agent or representative 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 reservation 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 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 necessary 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 and to federal and state entities, as required by law.

Applicant's Signature: _____ Date:_____

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public Signature: _____ (L.S.)

For: _____

My Commission Expires: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided.

☐ Any valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card? Number _____; Date of Expiration: _____

☐ Any valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit? State: _____; Number_____; Date of Expiration: _____.

☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.

☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____

☐ Certificate of Naturalization with intact photo.

☐ Certificate of (US) Citizenship with intact photo.

☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

_____

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and 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 Date

_____

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The 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.

06/28/12 Affidavit of Eligibility

THIS SPACE FOR OFFICE USE ONLY

APPLICATION FOR
RESPIRATORY CARE PRACTITIONER
LICENSURE

Issued by the

South Carolina Department of Labor, Licensing
and Regulations
Board of Medical Examiners
110 Centerview Drive
Post Office Box 11289
Columbia, South Carolina 29211
(803) 896-4500

Approved by Board /Committee Member:

_____
Board/Committee Member Signature

_____
Date Approved

GENERAL INFORMATION

Date of Birth: _____

Place of Birth: _____

Sex: _____ Race: _____

Height: _____ Weight: _____