



APPLICATION TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER REQUIREMENTS AND INSTRUCTIONS

You must follow these instructions to obtain a registration to practice as a Respiratory Care Practitioner in South Carolina. An applicant shall comply with the following requirements as outlined in S.C. Code §40-47-510, 40-47-600, and 40-47-610 of the [Medical Practice Act](#).

REQUIREMENTS FOR LICENSURE

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.

CERTIFICATION

Applicants must submit a current copy of your certification as a Certified Respiratory Therapist (CRT) or Register Respiratory Therapist (RRT) with the [National Board for Respiratory Care, Inc](#) or examination results for examination for certification as a CRT or RRT must be included with this application. Verification directly from the NBRC may be required if appropriate documentation is not provided.

EDUCATION

Applicants must submit a copy of the transcript or diploma from their respiratory care educational program.

EMPLOYER/PHYSICIAN SPONSOR INFORMATION

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. Before you can begin working in South Carolina, you must notify the Board by email at medboard@llr.sc.gov of where you will be working, in South Carolina, and who the medical director will be.

PHYSICIAN SPONSOR STATEMENT

Applicants who will be performing home health care duties will need to complete the Physician Sponsor Statement.

VERIFICATION OF LEGAL NAME

A license must be issued in the applicant’s legal name as verified by a vital statistics birth certificate (not hospital birth certificate), valid driver’s license, passport or other legal document acceptable to the board. Examples of acceptable legal name change documents include a marriage certificate, divorce decree or court order approving legal name change.

CRIMINAL BACKGROUND CHECK (CBC) PROCESS

Applicants applying for a respiratory care practitioner license with the SC Board of Medical Examiners will be subject to a state and national fingerprint criminal background check. The fingerprint criminal background checks are required pursuant to § 40-47-36 of the South Carolina Code of Laws.

Instructions for the fingerprint process will be sent to the applicant after their application for licensure is received by the South Carolina Board of Medical Examiners. DO NOT have your fingerprints or CBC report processed until you have applied and received instructions from the board. Submittal of the fingerprints prior to application will cause an automatic rejection of the criminal background check and fingerprints will need to be submitted again to complete the application.

OUT-OF-STATE LICENSE VERIFICATION

If you currently hold or have previously held a license, certification or registration for any medical profession, please list details below. You will need to contact each state board and have an official license verification sent directly to the Board via email: Medboard@llr.sc.gov or mail.

ADDITIONAL INFORMATION

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.

Note: It is the policy of the Board to require 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 is issued.

A person may not willfully practice or offer to practice as a Respiratory Care Practitioners unless that person is registered by the department. A person who uses the title Respiratory Care Practitioners in any advertisement, business card or letterhead, or billing document or who makes another verbal or written communication indicating that the person is a Respiratory Care Practitioners or who acquiesces in that representation violates this section.



APPLICATION TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER

Documentation required for your application:

- Check or money order in the amount of \$110 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
- [Notarized Verification of Lawful Presence Form](#)
- A 2"x2" passport-type photo
- Copy of CRT or RRT National Board Certificate or examination results
- Copy of Respiratory Care Diploma or have an official transcript sent to the Board
- Physician Sponsor Statement, if performing home care duties
- **Verification of Legal Name:** A license must be issued in the applicant's legal name as verified by a vital statistics birth certificate (not hospital birth certificate), valid driver's license, passport or other legal document acceptable to the board. Examples of acceptable legal name change documents include a marriage certificate, divorce decree or court order approving legal name change.

Documentation to submit to the Board's Office from the issuing agent via email:

Medboard@llr.sc.gov or mail:

- License Verification from each state medical board that you are currently or have ever been licensed in.
- Criminal Background Check (CBC) – Board will forward instructions once application is received.

APPLICANT INFORMATION

Last Name: _____ First: _____ Middle: _____ Suffix: _____

Have you ever legally changed your name? Yes No Prior Name: _____

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: _____ City: _____ State: ___ Zip: _____ District: _____

Mailing Address: _____ City: _____ State: ___ Zip: _____

(If different than above)

Phone: _____ Email Address: _____

Date of Birth: _____ Social Security Number: _____

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

Race: _____

(for statistical purposes only)

Gender: Female Male

EMPLOYER INFORMATION

SC Medical Director: _____ S.C. License Number: _____

Business Address: _____

Business Phone: _____ Business Email Address: _____

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.

PROFESSIONAL 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 the school. If additional space is needed, you may attach an additional sheet.

Institution/Program	Location (City and State or Country)	Graduation/Program Completed?	Degree Earned

RECORD OF EXAMINATION

Complete the requested information below if any national or state licensure examination was taken for respiratory care. A copy of your 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				

RECORD OF LICENSURE

If you currently hold or have previously held a license, certification or registration for any medical profession, please list details below. You will need to contact each state board and have an official license verification sent directly to the Board via email: Medboard@llr.sc.gov or mail. If you hold or have held licenses in additional states, please list them on [State License Verification Form](#) including the license type, state name, license number.

State/ Jurisdiction	License/ Certification/ Registration Number	Type of License/ Certification/ Registration	State/ Jurisdiction	License/ Certification/ Registration Number	Type of License/ Certification/ Registration

MEDICAL PRACTICE EMPLOYMENT HISTORY

List all medically related employment (not training or residency) chronologically, most recent first, 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 MM/YR	To MM/YR	Employer Name	Office Address	Type of Practice

PERSONAL HISTORY INFORMATION

If you answer yes to any of the questions below, you must attach an [Explanation of “Yes” Answer Form](#). Additional information/documentation may be required.

1. Have you discontinued the practice of respiratory care therapy for any reason for four consecutive months or more? Yes No

2. Have you been arrested, charged, convicted of, or pled guilty or nolo contendere to, a criminal offense of any kind, whether or not a sentence was imposed or suspended, except a minor traffic offense? (A DUI or similar alcohol-related driving offense is not a minor traffic offense and must be reported.) Yes No
 If yes, include official court documentation along with the disposition with the [Explanation of “Yes” Answer Form](#).

3. Do you have any physical or mental disease or condition, including an addiction to drugs or alcohol, that currently interferes with your ability to competently and safely perform the essential functions of practice? (If you are voluntarily enrolled in the Recovering Professionals Program (RPP) and have remained in full compliance, you may answer ‘No’ with respect to any condition involving abuse of alcohol or drugs. If you have a physical or mental disease or condition that is appropriately being treated and does not currently impair your judgment or otherwise adversely affect your ability to practice, you may answer ‘No.’) Yes No

4. Have you had a malpractice lawsuit filed against you, a judgment returned/filed against you, or settled a medical malpractice claim? Yes No
 If yes, how many? _____
 (Complete a Malpractice Information Claim Form for each claim)

5. Has any licensing agency revoked, suspended, restricted, sanctioned, fined, reprimanded, or otherwise disciplined any occupational or professional license, certificate, or registration you have held? Yes No
 If yes, provide an official copy of the board order and any supporting documentation with the [Explanation of “Yes” Answer Form](#).

6. Have you had an application to practice respiratory care/therapy denied or refused by another medical/respiratory care licensing board or other entity? Yes No

7. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, federal or state agency, health care facility, professional association or other entity? Yes No
8. Have you voluntarily surrendered any license related to your practice as a respiratory care practitioner? Yes No
9. Have you ever voluntarily surrendered hospital privileges or had any hospital privileges denied, revoked, suspended or restricted in any way? Yes No
10. Have you resigned from any hospital, institution or health care facility in lieu of disciplinary action? Yes No

CERTIFYING STATEMENT

I, _____(print name), affirm that I am the person described and identified, and the person named in all 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 medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, 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 understand that I may be contacted by the Board and asked to sign a release for records should my application reveal additional information is necessary to approve my application.

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 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.

I affirm that 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 to the best of my knowledge. I understand that I am declaring under penalty of perjury under the laws of South Carolina that the information provided within this application is true and correct to the best of my knowledge. (S.C. Code 16 9 10(A)(2) “It is unlawful for a person to willfully give false, misleading, or incomplete information on a document, record, report, or form required by the laws of this State.”) Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute cause for denial, cancellation, 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, telephone number, and email address.

Signature of Applicant

Print Name of Applicant

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

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.



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: _____

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)