Applicant First Name: **Applicant Last Name:**
ID: **Transaction Date:**
License Type: **Trace Number:**
Amount Paid:

Text Facsimile of Online Respiratory Care Practitioner Application

Login

Respiratory Care Practitioner Application

- Information you enter will be automatically saved at the end of every page.
- You must complete the application within 15 day or your information will be deleted.
- Some of the questions may direct you to download a supplemental form and submit it, along with any relevant records.
- Pay the license fee using one of the following:
  - MasterCard,
  - Visa,
  - Discover,
  - American Express, or
  - Electronic Check.

Please enter the following information carefully as it will be used to track your application and allow you to access it again

Asterisk (*) indicates response required.

Email Address:

Date of Birth*:

Alternate Text that appears if logging in and information has been saved.

Our records indicate that within the last 15 days, you began the online application process. Any updates made at that time were saved. Would you like to use this saved information or start the application process over? Click the “Use Recent Updates” button to use updates made within the last 15 days, otherwise click the “Start Over” button.

Identification

You are applying for the Respiratory Therapist Permit. Please be advised that a false response to any question may be grounds for the denial of your application for a permit and such denial may be made public and reported to other authorities.

Asterisk (*) indicates response required.

Full Name as you wish it to appear on your receipt*:

First Name*:

Middle Name:

Last Name*:

Date of Birth (MM/DD/YYYY)*:

Email Address:

Social Security Number (XXX-XX-XXXX or XXXXXXXXX)*:

Are you currently on active duty in the U.S. Military? *:

An applicant headquartered in Texas who is an active duty military service member, or the spouse of an active duty military service member, may be eligible for expedited handling. If you think you may qualify please select the appropriate box:

Military Service Member (active duty):

Spouse of a Military Service Member (active duty):

Address Information Section

Please provide your mailing address and daytime U.S. phone number. It is your responsibility to notify the Board in writing if you have a change of address.

All correspondence will be sent to the mailing address. When entering a foreign address leave the State blank and provide a Country.

Asterisk (*) indicates response required.

Mailing Address

Mailing Address 1*:

Mailing Address 2:

Mailing City*:

Mailing State*:

Mailing ZIP Code*:

Mailing Country*:

Telephone Number ###-###-####*:

Licenses

Please list any and all other health care license(s), registration(s), or certificates(s) that you possess or have possessed e.g. (RN/LVN/PT/AT/EMT/ECA/OTHER).

State/Territory:

Title of Certificate or License:

Number:

Issue Date (MM/YYYY)*:

_____

Work Experience

- Please account for all periods of work from the time you graduated from respiratory care education program to the present date.
- Include all periods of unemployment or employment outside the field of medicine. For periods of unemployment, use your home address.
- To indicate a current position, enter today's date as an end date.

Add Work Experience

Add Work History

Asterisk (*) indicates response required.

Position*:

Department*:

Start Date (MM/YYYY)*:

End Date (MM/YYYY)*:

Facility/Employer

Name*:

Street*:

City*:

State:

ZIP/Postal Code*:

Province:

Country*:

Phone Number:

_____

Questions

Asterisk (*) indicates response required

Question 1*

Are you applying for a temporary permit?	

If you have completed a degree at an accredited college or university, please enter it below:	
Type of Degree:	
Your name at time of graduation:	
First Name:	
Middle Name:	
Last Name:	
Name of College or University:	
City of College or University:	
State of College or University:	

Arrest/Criminal History

This is important.

The Board will run queries with the Texas Department of Public Safety and the FBI to verify your criminal history. Both entities maintain records, often beyond the time that courts keep them. Please be aware that if you have **ever** been arrested, charged, or convicted of a misdemeanor or a felony, the record of those events will be reported as a result of the fingerprint inquiry.

Serious traffic offenses such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether an offense should be disclosed, it is better to disclose the offense on the application.

Matters in which you were diverted, deferred, pardoned, or pled nolo contendere MUST be disclosed.

If you believe your offense was **sealed or expunged**, you **must** be able to provide a copy of the expunction or non-disclosure order if requested.

If you are in doubt as to how to respond to the questions, full and honest disclosure is highly recommended.

If you answer "Yes" to any question in this section, you are required to submit records and a statement. See Form R.

Question 1*

Have you ever been arrested?	

Question 2*

Have you ever been charged with any violation of the law regardless of outcome? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less).	

Question 3*

Are you currently the subject of a grand jury or criminal investigation?	

Question 4*

Have you ever been placed on probation?	

Question 5*

Have you ever been granted deferred adjudication or any other type of pretrial diversion? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and, 2) violations with fines of $250 or less.)	

Question 6*

Have you ever been convicted of an offense or imprisoned?	

Mental and Physical Health

If you answer "Yes" to any of the following questions, you are required to submit Form W.

Question 7*

Have you self-referred to the Texas Physicians Health Program? What is PHP?	

Question 8*

Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated or monitored for alcohol or substance abuse/dependency?	

Question 9*

Within the past five (5) years, have you been diagnosed with or treated for any: psychotic disorder, delusional disorder, mood disorder, major depression, personality disorder, or any other mental condition which impaired or does impair your behavior, judgment, or ability to function in school or work?	

Question 10*

Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic, which impaired or does impair your behavior, judgment, or ability to function in school or work?	

Question 11*

If you answered "Yes" to questions 9 or 10, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program?	

Attestation

I affirm that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein, and evidence or other credentials submitted herewith, are true and correct; that I am the lawful holder of the required certificate and/or educational degree as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, was procured without fraud or misrepresentation or any mistake of which I am aware.

Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business or professional associates (past, present and future) and all governmental agencies (local, state, federal, or foreign) to release, to the Texas Medical Board or its successors, any information, files or records, including medical records, educational and training records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Board in connection with this application, necessary to determine my professional competence, professional conduct, or physical and/or mental ability to safely engage in the practice as a respiratory care practitioner. Any materials submitted to the Board in connection with this application process become the property of the Texas Medical Board and will not be returned. I acknowledge that the Board may release any information or materials, submitted to the Board in connection with this application process, to others as allowed or required by state or federal law.

I hereby affirm that I will provide the Board with updated information to be received by the Board within 15 days of my becoming aware of any event that occurs after submission of my application that renders any response, although complete and correct when made, no longer complete or correct. Further, I understand that failure to provide updates may result in an adverse action against my application.

I understand that falsification or misrepresentation of any item or response on this application or any supplemental information is a sufficient basis for a denial or revocation of a license, a determination of ineligibility, or another adverse action against my application or my license after issuance. I hereby affirm that I have read and agree to abide by the specific laws and rules associated with a license to practice respiratory care in this state.

I agree to these terms.

The applicant checks a box to indicate agreement and cannot continue to payment until they do.