Georgia Composite Medical Board Use Only

Temporary #: _____ File Number: _____

Date Issued: _____ License Number: _____

Date Issued: _____

Initial Respiratory Care Professional Application

All fees are nonrefundable and subject to change.

Name and Personal Detail

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. §651 and 20 U.S.C.A. § 1001. This information may also be disclosed to the National Practitioner Data Bank or other state medical boards or regulatory agencies for license tracking purposes.

Social Security Number _____

Last Name (Surname) _____

First _____

Middle _____

Other Surnames _____

Gender □ Male □ Female

Birth Date (mm/dd/yy) ____/____/____

Contact Detail Summary

General Addresses

Mailing Address: Correspondence from the Board is sent to this address. Email address is utilized by the Board to contact you in case of an emergency situation. This address will not appear on the Internet *unless you **fail** to provide a practice location address*.

Street Number Street Name City State Zip Apt

Area Code Phone Number Email _____@_____

Practice Location: Posted on the Internet when the license number is issued.

!!Your mailing address will appear on the Internet if you do not provide a practice location!!

Street Number Street Name City State Zip Suite/Bldg

Area Code Phone Number

RESPIRATORY CARE PROFESSIONAL
PROGRAM QUESTIONS

1.	How long have you lived in the U.S.? _____/_____ Years/Months

		YES	NO
2.	Have you served in the armed forces? If Yes, dates of service: from: _____ to: _____ (provide copy of DD214 to Board)	___	___
3.	Have you been discharged from the armed forces? If yes, provide a copy of your discharge summary to the Board.	___	___
4.	Are you certified/registered by the National Board of Respiratory Care? If yes, please complete Form D (NBRC Credentials Verification Form)	___	___
5.	Are you a U.S. Citizen? If you are not a U.S. citizen, you must submit documentation that will determine if you have a qualified alien status. **Only those applicants who can provide proof will be granted a license.** The Board participates in the **DHS-USCIS SAVE** (Systematic Alien Verification for Entitlements or "SAVE") program for the purpose of verifying citizenship and immigration status information of non-citizens. In order to confirm your status with the SAVE program, you need to provide the board with **legible** copies of **one** of the documents listed on our website.	___	___

RESPIRATORY CARE PROFESSIONAL
APPLICANT QUESTIONNAIRE

	If you answer YES to any of the Applicant questions below, you are required to furnish appropriate documents, including complete details, date, place, reason and disposition of the matter (include copies of court orders or malpractice suits, if applicable) and send these documents with your application or mail these documents directly to the Board. Please make sure your documents clearly identify you and the type of profession you are applying for.	**YES**	**NO**
1.	Has any board or agency denied issuance of or pursuant to disciplinary proceeding refused renewal of certificate?	___	___
2.	During the last seven years, were you treated for alcohol, mental or physical disorder, chemical drug dependency, neurologic, or psychiatric illness that required outpatient evaluation or inpatient hospitalization? (If yes, provide treatment history documentation to include diagnosis, treatment regimen, hospitalization, and ongoing treatment/medication to the Board.	___	___
3.	Have you entered a plea bargain, been arrested, indicted or convicted for violating any state or federal law including DUI (excluding minor traffic violations)? As used in this question, the term "conviction" shall include a finding or verdict of guilt, or a plea of guilty, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered.	___	___
4.	Have you ever been denied the privilege of taking an examination given by any state licensing Board or been denied a certificate/license?	___	___
5.	Has any licensing Board or agency ever taken a **public or private** disciplinary action against you?	___	___
6.	Have you ever been denied membership in any professional society or association?	___	___
7.	Have you ever been denied membership in any professional society or association?	___	___
8.	Are you in default on a state or federally funded and/or guaranteed school loan?	___	___
9.	Have you ever been, or are you currently, the subject of an investigation by any licensing Board or agency?	___	___
10.	Have you ever been dismissed or resigned while under investigation at a hospital?	___	___
11.	Have you ever defaulted on child support payments?	___	___
12.	Did you include a copy of your CV or résumé with this application packet?	___	___
13.	Date you began working as a Respiratory Therapist in Georgia? DATE:_____/_____/_____		

License History

List all states in reverse chronological order that you are/have been licensed to practice as a Respiratory Care Professional by virtue of a certification issued by another duly constituted licensing Board in the United States:

State	Licensed From (mm/dd/yyyy)	Licensed To (mm/dd/yyyy	License Status (Circle One)
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive

OTHER HEALTH RELATED LICENSES

Record below the State(s) where you hold or have held license to practice any other **health related profession**

State	Type of License	Date License was Issued Month/Year	License Status (Circle One)
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive

Respiratory Care Education

Enter name and location of Respiratory Care Education.

School Name:	
City:	
State :	
Zip Code :	
Date from:	(mm/dd/yyyy)
Date to:	(mm/dd/yyyy)

School Name:	
City:	
State:	
Zip Code:	
Date from:	(mm/dd/yyyy)
Date to:	(mm/dd/yyyy)

Respiratory Care - Other Education Received ☐ N/A

Enter name and location of other education.

Name of school:	
City:	
State:	
Zip Code:	
Date from:	(mm/dd/yyyy)
Date to:	(mm/dd/yyyy)
Type of Degree:	

Name of school :	
City:	
State:	
Zip Code:	
Date from:	(mm/dd/yyyy)
Date to:	(mm/dd/yyyy)
Type of Degree:	