



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Requirements for *All* Applicants

These requirements pertain to *all* applications – **including both new applications and re-applications** – for Delaware licensure.

- Submit completed, signed and notarized [Application for Licensure as a Respiratory Care Practitioner](#) form.
 - Make sure all questions are answered unless the instructions tell you to skip a question.
 - Read the AFFIDAVIT section.
 - Sign the application in front of a notary public.
- Enclose the non-refundable [processing fee](#) by check or money order made payable to “State of Delaware.”
- If you now hold, or have ever held, a Respiratory Care Practitioner license in any jurisdiction (state, U.S. territory, District of Columbia) other than Delaware, arrange for the Council office to receive a *Verification of Respiratory Care Practitioner License* form from *each* jurisdiction where you have held a license.
 - Before forwarding the form, check whether the jurisdiction requires a fee.
 - The Council office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction’s seal must be affixed to the form.
 - Internet or faxed verifications will not be accepted.
- Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
 - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.
- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirements for Applications *Other Than Re-Applications*

These requirements pertain to all applications for Delaware licensure ***other than re-applications***. If you are re-applying for Delaware licensure that lapsed, see the **Additional Requirements for Re-Applications** section below.

- Submit an 8" X 11 1/2" copy of your Respiratory Care Practitioner diploma.
- Arrange for the Council office to receive a *Verification of Respiratory Care Practitioner Education* form from *each* program you attended.
 - The Council office must receive the completed form *directly* from the school. The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
 - Internet verifications or faxed verifications will not be accepted.
- Submit an 8 1/2" x 11" copy of your National Certifying Certificate.
- Arrange for the Council office to receive a credential verification letter to be sent directly from the National Board of Respiratory Care (NBRC) to the Council office.
 - To request verification, follow the instructions on the NBRC website at [Credentialed Practitioners](#).

Additional Requirements for Re-Applications

These additional requirements apply *only if* you are re-applying for Delaware licensure that you previously held but which can no longer be renewed because it lapsed over three years ago. What you are required to submit depends on whether you have been actively practicing respiratory care outside Delaware in the three years before your re-application.

IF you have...	THEN...	AND you must submit proof that you...
<u>not</u> actively practiced respiratory care for the past three years	submit documentation from the NBRC that you have passed the NBRC Entry Exam during the two years before your re-application	completed 20 hours of continuing education in the two years before your re-application.
actively practiced respiratory care for the past three years	enter information about your active practice on the application.	

- For information on acceptable continuing education, see Section 8.0 of the Respiratory Practice Advisory Council [Rules and Regulations](#).



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER

TYPE OF APPLICATION

1. Select the type of Respiratory Care Practitioner (RCP) application you are filing (check one):
 - Application – I have never been licensed as an RCP in Delaware and am applying for a new Delaware license.
 - Re-Application – I previously held a Delaware RCP license that has been lapsed over three years and is no longer renewable. My license number was: C9 - _____.

IDENTIFYING AND CONTACT INFORMATION

2. Full Name: _____
Last First Middle
3. Other Names Used: _____ None
4. Date of Birth (month/day/year): _____ Gender: Male Female
5. Have you been issued a U.S. Social Security Number? Yes No If yes, enter your SSN: _____
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
6. Mailing Address: _____
City State Zip
7. Phone: _____ Home Work Email: _____ None

RESPIRATORY CARE EDUCATION & CERTIFICATION – Applicants *by re-application* may skip this section.

8. Enter complete information about your respiratory care education.

SCHOOL NAME	LOCATION	DATES ATTENDED	DEGREE RECEIVED

Submit an 8 1/2" X 11" copy of your respiratory care program diploma and arrange for the Council office to receive a *Verification of Respiratory Care Education* form directly from each school you listed.

9. Have you ever been deemed ineligible to sit for the NBRC Entry Level Exam for any reason? Yes No If yes, explain: _____
10. Have you taken and passed the NBRC Entry Level Exam? Yes No
 - If yes, enter the date you sat for the exam: _____
 - If no, enter the date of the exam for which you have registered: _____

11. Are you NBRC certified as a Respiratory Care Practitioner? Yes No

Submit an 8 1/2" x 11" copy of your National Certifying Certificate. Also, arrange for the Council office to receive a credential verification letter sent *directly* from the NBRC to the Council office.

LICENSURE HISTORY – All applicants complete this section.

12. Have you ever been denied a license or a registration to practice as a Respiratory Care Practitioner? Yes No

If yes, explain: _____

13. Have you ever held a Respiratory Care Practitioner license in any jurisdiction other than Delaware? Yes No

If yes, list *each* jurisdiction where you now hold, or have ever held, a respiratory care practitioner license.

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

Arrange for the Council office to receive a *Verification of Respiratory Care Practitioner License* form from *each* jurisdiction you listed.

PRACTICE AND CONTINUING EDUCATION – Only applicants *by re-application* complete this section.

14. Have you completed 20 hours of continuing education in the two years before re-applying? Yes No

Submit proof of completing at least 20 hours of acceptable continuing education in the past two years.

15. Have you actively practiced respiratory care *for the past three years*? Yes No

- **If no, continue with the next question.**
- **If yes, enter the following information about your practice over the past three years and then skip to the DISCLOSURES section.**

EMPLOYER	LOCATION (City & State)	EMPLOYMENT DATES	
		From (month/year)	To (month/year)

16. Have you re-taken and passed the NBRC Entry Level Exam *in the past two years*? Yes No

- **If yes, enter the date you sat for the exam:** _____
- **If no, enter the date of the exam for which you have registered:** _____

Arrange for the Council office to receive a credential verification letter sent *directly* from the NBRC to the Council office.

DISCLOSURES – All applicants complete this section. If a question in this section directs you to submit a signed statement to explain your answer, the statement should specify where and when the incident occurred, issues involved and any further information you wish to provide.

17. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes No **If yes, submit a signed statement explaining fully.**

Arrange for the Council office to receive State of Delaware and Federal Bureau of Investigation criminal background checks.

18. Are any criminal charges pending against you in any jurisdiction? Yes No **If yes, submit a signed statement explaining fully.**

19. Have you ever been the subject of any disciplinary action (formal or informal) by a healthcare facility or any entity governing respiratory care licensure or is any such action pending against you? Yes No **If yes, submit a signed statement explaining fully.**
20. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes No **If yes, submit a signed statement explaining fully and provide a copy of any documents in your possession related to the final disposition of the investigation. Continue with the next question. If no, skip to Question 22.**
21. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes No
22. Within the past two years, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a respiratory care practitioner, including use or abuse of dangerous or addicting substances? Yes No **If yes, submit a signed statement explaining fully. If no, skip to the DUTY TO REPORT section.**
23. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes No

DUTY TO REPORT

24. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
 - mentally or physically unable to engage safely in the practice of medicine
 - excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A](#) and that I understand my *duty to report*. Yes No

25. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes No

26. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to self report all of the following:
- Any change in hospital allied healthcare privileges and any disciplinary action taken by any medical society against you within 30 days (24 Del. C. §1730(b)(1))
 - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 Del. C. §1730(b)(2))
 - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 Del. C. §1730 (c))
 - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 Del. C. §1731A (f))
 - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 Del. C. §1730 (d))
 - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 Del. C. §1730 (d))

I certify that I have read and understand all of provisions in the [Delaware Medical Practice Act](#), including those listed above, and understand my *duty to self report*. Yes No

Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.

The Board office must receive all of these items no later than 4:30 PM ten full working days before the Council's next meeting date in the event that your application requires the Council's review:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine whether I have previously engaged in unprofessional conduct as defined in Section 6.3 of the Regulations of the Delaware Respiratory Care Practice Advisory Council and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Respiratory Care Practice Advisory Council any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Respiratory Care Practice Advisory Council or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Delaware Respiratory Care Practice Advisory Council will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Council has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Council.

Signature of Applicant: _____ **Date:** _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)

By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)

By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430**

**DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.
DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.**

⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.



DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM



Fax or Mail Request to: OCCL, Criminal History Unit
Concord Plaza, Hagley Building
3411 Silverside Road
Wilmington, DE 19810
Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- Allow 15 working days for results to be processed.
Do not use a cover sheet.
Do not send duplicate requests.
Form must be submitted to DSCYF within 90 days of signature date in order to be processed.

PART I. APPLICANT INFORMATION - Type or print clearly.

Name: Last First Middle

Other Name(s) Used: DE Drivers License #:

Social Security #: Date of Birth: mm / dd / yyyy Sex: Male Female Race:

Address: Street City State Zip

Have you ever been involved in a substantiated case of child abuse or neglect? Yes No If Yes, explain:

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry.

Signature: Date:

Parent or Guardian Signature if applicant is under the age of 18:

PART II. AGENCY/ORGANIZATION INFORMATION

Please check only one:
[] EDUCATION [] HEALTH CARE FACILITY [] CHILD CARE [X] OTHER: State Agency

Agency Identification Number (if applicable): 1179
Requesting Agency Name: Division of Professional Regulation
Address: Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904
Phone: (302) 744-4500 Fax: (302) 739-2711 Contact Person: Nicole Williams

DSCYF USE ONLY
The individual listed above (is listed) (is NOT listed) on the Delaware Child Protection Registry.
Date: DSCYF Criminal History Unit



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF RESPIRATORY CARE PRACTITIONER LICENSE

Send a form to *each* jurisdiction (other than Delaware) where you have ever held a license to practice as a Respiratory Care Practitioner.

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ Date of Birth: _____		
	Other Name(s) Used: _____		
	License Number(s) in Jurisdiction Named Above: _____		
	<p>I am applying for licensure as a Respiratory Care Practitioner in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Respiratory Care Practice Advisory Council.</p>		
Applicant Signature: _____		Date: _____	
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/U.S. Territory of _____ License Number: _____		
	Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____		
	Has any discipline activity taken place regarding this licensee? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please enclose a certified copy of the Board Order with this license verification.		
	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.		
CERTIFICATION AFFIX OFFICIAL SEAL HERE	Printed Name of Official: _____		
	Signature of Official: _____		Date: _____
	Title: _____		
	Phone: _____	Fax: _____	Email: _____

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF RESPIRATORY CARE PRACTITIONER EDUCATION

Respiratory Care Practitioner applicants should send this form to *each* program attended.

Educational Institution: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____ SSN: _____ Birth Date: _____ Other Name(s) Used: _____ I am applying for licensure as a Respiratory Care Practitioner in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form. Applicant Signature: _____ Date: _____		
	This section to be completed by Institution. 1. Enter the dates the applicant named above was enrolled in your institution: From (month/day/year): _____ To (month/day/year): _____ 2. Was the applicant awarded a degree? Yes <input type="checkbox"/> No <input type="checkbox"/> • If <u>yes</u> , enter: Degree Received: _____ Date Degree Conferred (month/day/year): _____ • If <u>no</u> , attach explanation of reason applicant did not receive a degree.		
AFFIX INSTITUTION OR NOTARY SEAL HERE	I certify that the information above is an accurate account of the applicant's records and is true and correct. Printed Name of Institution Official: _____ Signature of Official: _____ Date: _____ Title: _____ Phone: _____ Fax: _____ Email: _____		
	(This area is reserved for the official seal and signature of the institution or notary.)		

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.