

REPLACEMENT REQUEST
Change Name and Address
Order Replacement Card or Certificate
Complete and Mail to:
Ohio Respiratory Care Board
77 South High Street, 16th Floor
Columbus, OH 43215-6108
614-752-9218

Instructions:

- 1) Please complete sections A, B, and C of this form. **Print or Type ONLY.**
- 2) Document **MUST** be notarized in Section C.
- 3) Cost for I.D. card is \$6.00 - Cost for Wall Certificate is \$10.00.
- 4) Make checks Payable to: **TREASURER, STATE OF OHIO.**

Section A

Old Name
Address

Last Name	First Name	MI
Street Address		
City	State	Zip Code
		County

Section B

New Name

New Address

Last Name	First Name	MI
Street Address		
City	State	Zip Code
		County
Employer	Street Address	
City	State	Zip Code
		County

Section C

- \$6.00 Card Replacement
- \$10.00 Certificate Only

Please check one or both if ordering a new I.D. or certificate

License Number	
Home Phone Number	Work Phone Number
Reason for Replacement (lost, destroyed, or stolen)	

AFFIDAVIT

Any applicant who knowingly makes a false statement on this form is guilty of a misdemeanor of the first degree under Section 2921.13 of the Ohio Revised Code.

Licensee Signature Date

Sworn and subscribed before me, Notary Public in and for _____ County, State of Ohio, on this _____ day of _____, _____ (year).

RCB 017 (3/03)

www.state.oh.us/rsp

Signature of Notary
