



Ohio Respiratory Care Board
77 S. High Street, 16th Floor
Columbus, OH 43215-6108

(614) 752-9218 - Office
(614) 728-8691 - Fax
www.respiratorycare.ohio.gov

Respiratory Care Professional License Reinstatement for Lapsed or Inactive Licenses

PLEASE CAREFULLY READ INSTRUCTION BELOW BEFORE YOU CONTINUE!

Incomplete or incorrect applications will be returned!

1 CONTACT INFORMATION (Please print or type)

Full Name (First, Middle and Last Name)	
Street Address (Number and street or rural route)	
City, State and Zip Code	
PHONE NUMBER REQUIRED:	County of Residence
Home	Work
EMAIL ADDRESS:	

2 SOCIAL SECURITY NUMBER * (last four digits)

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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* Your Social Security Number is required by state law and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the Federal Healthcare Integrity and Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61). It may also be used for reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4761.031, and/or as otherwise required by state and federal law.

By providing the last four digits of your Social Security Number on this application and signing this application, you are confirming this information matches the Social Security Number you submitted on your original application for a Respiratory Care Professional license.

3 EMPLOYER INFORMATION (List full business name and address.) DO NOT abbreviate. If unemployed, indicate "NOT EMPLOYED".

Employer Name
Street Address (Number and street or rural route)
City, State and Zip Code

4 CRIMINAL CONVICTIONS

Complete this section by initialing Yes or No to the following question. (See page 3 for instructions)

Since your last license renewal date with the Ohio Respiratory Care Board or since your initial licensure date, have you been convicted of, found guilty of, pled guilty to, pled no contest to, received intervention or treatment in lieu of conviction, or received diversion in lieu of conviction for a criminal offense (felony or misdemeanor) in any state in violation of any federal, state, or municipal ordinance, excluding minor misdemeanor traffic offenses?

IF YOU INITIALED "YES" TO QUESTION #4, PLEASE SUBMIT CERTIFIED COPIES OF THE COURT JUDGMENT OR JOURNAL ENTRY.

Initial One

YES NO

Initial Initial

5 RESPIRATORY CARE CONTINUING EDUCATION (select one of the following)

Complete this section and then attach RCCE documents, proof of exam, or state verification as required (See page 3 for instructions)

Pursuant to OAC rule 4761-8-01(G), if your license has been expired/lapsed or inactive for less than five years, you are required to complete continuing education to renew this license. The amount of continuing education is based on the length of time since your last renewal date. (See instructions: Section 5)

Have you completed your entire continuing education requirements in compliance with OAC 4761-9-02?

or

If you have been inactive or expired/lapsed for more than five years, you are required to retake and pass a recognized examination in accordance with OAC 4761-5-01 or demonstrate current licensure in a state whose standards for licensure are at least equal to those in effect in Ohio. (See instructions: Section 5)

Have you taken a recognized examination in compliance with OAC 4761-5-01 or are you currently licensed in a state(s) whose standards for licensure are at least equal to those in effect in Ohio?

Initial One

YES NO

Initial Initial

Initial Initial

6 PRACTICE QUESTIONS

Since your last renewal, have you:

Initial One

YES NO

A. Been denied a license to practice respiratory care or another healthcare profession by any state or U.S. territory (excluding license denials made by the Ohio Respiratory Care Board)?	Yes	No
B. Been disciplined in any state or U.S. territory you currently hold or have ever held a license to practice respiratory care or another healthcare profession (excluding disciplinary actions taken by the Ohio Respiratory Care Board)?	Yes	No

Page 3, Respiratory Care Professional Reinstatement

Purpose. Complete this form if you would like to reinstate/renew your Respiratory Care Professional license to practice respiratory care in the State of Ohio.

Instructions

Complete the entire form in **blue or black** ink. Incomplete applications may be returned and delay the processing of your application. Enclose a check or money order for the appropriate renewal fee and return in the enclosed envelope.

The Board assumes no responsibility for lost, late, delayed, torn, separated, misdirected mail or illegible and incomplete applications.

Section 1: Your Information.

This is the official name and address appearing on the State's licensure system. If your information has changed or it is incorrect, please report any corrections in the space provided.

Note: If your name has changed due to marriage or divorce, please submit a copy of your marriage license, divorce decree, or other document and complete Section 8 personal affidavit.

Sections 2: Social Security Number

This information is required by state law and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the Federal Healthcare Integrity and Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61). It may also be used for reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4761.031, and/or as otherwise required by state or federal law.

Your signature on this form affirms that you have been advised of these reporting requirements and the Board's use of this information for these purposes.

Section 3: Employer Information.

Please list your current employer. List the full and accurate name of the business and the full address of the business. If not employed, indicate "NOT EMPLOYED" on the employer name line.

Section 4: Criminal Conviction.

All license holders must complete this section. If you answered "yes", submit a certified copy of the Court's journal entry of your conviction(s). You may obtain this from the Clerk of Court's office in the jurisdiction in which you were convicted. You need not report minor misdemeanor traffic offenses. Please direct any questions you may have regarding convictions to the Enforcement & Compliance Unit at 1(800) 338-9888 (Ohio residents only) or write to: Respiratory Care Board, Attn: Enforcement & Compliance Unit, 77 S. High Street, 16th Floor, Columbus, Ohio 43215-6108.

Section 5: Respiratory Care Continuing Education (RCCE) or Examination Requirements.

If a license has been inactive or lapsed for less than five years from the lapsed or expiration date on record:

You must provide proof of completing continuing education requirements due since the lapsed date or expiration date of your license on record. The Board staff can help you determine how many hours are due. **Contact us at (614) 752-9218.**

The current requirements are as follows:

A Respiratory Care Professional shall complete **twenty contact hours** of relevant RCCE each renewal period, unless a waiver is granted or an exception to the number of hours applies under paragraph (G)(2) rule OAC 4761-9-02. RCCE earned must include the following content requirement:

- (a) One contact hour of RCCE on Ohio respiratory care law or professional ethics as set forth in rule 4761-9-04 of the Administrative Code; and
- (b) At least fifteen of the required contact hours must include content relating to the provision of clinical respiratory care as defined under section 4761.01 of the Revised Code; and
- (c) The remaining four contact hours may include indirectly related content, including, but not limited to, activities relevant to specialized aspects of respiratory care, such as education, supervision, management, health care cost containment, cost management, health quality standards, disease prevention, health promotion, or abuse reporting.

If a license is lapsed or inactive for more than five years from the lapsed or expiration date on record:

You must provide proof of taking and passing a current examination pursuant to OAC 4761-5-01 or provide proof of current licensure in a state whose standards for licensure are at least equal to those in effect in Ohio.

Section 6: Practice Questions

Answer each question by **initialing** the Yes/No box.

Section 7: Payment Method.

Payment of fees must be made in the form of a check or money order, **DO NOT SEND CASH.** Make your check or money order payable to the **Treasurer, State of Ohio.**

Note: Fees are non-refundable

Section 8: Affidavit of Name Change

Section 8 is for a name change only! This section must be completed in front of a Notary Public. When bringing this form to a Notary Public, you must present a certified record documenting your name change. The following are acceptable forms of documentation: 1) Certified marriage certificate/abstract, 2) Certified divorce/dissolution decree, 3) Certified court record indicating name change, or 4) Certified documentation from another state/country consistent with the laws of that jurisdiction reflecting the name change.

Attach copy of document presented to renewal form!

Section 9: Applicant Certification and Notary

This section must be signed in front of a Notary Public. By signing and dating this form, you are affirming the accuracy and truthfulness of the information contained herein. In addition, you are authorizing your employer, educational institution or law enforcement agencies to release to the Board any information necessary to process this application. Last, you agree to permit the Board access to your information in accordance with OAC 4761-13-05(D) (2) (d) (ii).

2014 Ohio Respiratory Care Practice Workforce Data

The Ohio Respiratory Care Board is participating in a statewide effort to collect comprehensive workforce data for licensed health care professionals. In February 2012, Governor Kasich created the Office of Workforce Transformation (OWT) to coordinate and align workforce policies, programs and resources across the state. The Governor’s Office of Health Transformation (OHT) is also involved by coordinating health sector workforce activities. In collaboration with the Ohio Department of Health (ODH), the Board has developed the following survey that will align with nationally recognized Minimum Data Set requirements for all primary care disciplines. These data will add elements to Ohio’s minimum data set that are required for designation of federal Health Professional Shortage Areas, and aid in the development of an advanced primary care workforce-forecasting model to assist in planning for health professions education programs, recruitment, and retention strategies.

The Board is aware of the importance of data for effective workforce planning and policymaking in Ohio. This information is intended to be aggregated and made available to those interested parties, including the Governor, the Ohio legislature, the Governor’s Office of Workforce Transformation, the Ohio Department of Health, and the various health profession associations, as requested. The Board will also make the numbers generated from the survey publicly available on our website at www.respiratorycare.ohio.gov.

The Board again wants to thank Ohio respiratory care licensees for taking the time to answer these important workforce questions included in this year’s renewal process. Your assistance will positively influence the practice of respiratory care and the health of Ohioans.

License Information
<p>Do you work in the State of Ohio? <input type="radio"/> yes <input type="radio"/> no (If no, do not complete the remainder of this form.)</p> <p>License Number - _____</p>

Demographics
<p>What is your name? _____</p>
<p>What is your date of birth (mm/dd/yyyy)? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>What is your sex (check one)? <input type="radio"/> male <input type="radio"/> female</p>
<p>Ethnicity? You may choose not to furnish this information by choosing “I do not wish to furnish” selection.</p> <p><input type="radio"/> I do not wish to furnish this information.</p> <p><input type="radio"/> Hispanic, Latino, or of Spanish origin?</p> <p><input type="radio"/> Caucasian?</p> <p><input type="radio"/> Black or African American?</p> <p><input type="radio"/> American Indian or Alaska Native?</p> <p><input type="radio"/> Asian?</p> <p><input type="radio"/> Native Hawaiian or Other Pacific Islander?</p> <p><input type="radio"/> Other (please specify)? _____</p>
<p>Where were you born? You may choose not to furnish this information by choosing “I do not wish to furnish” selection.</p> <p><input type="radio"/> I do not wish to furnish this information.</p> <p><input type="radio"/> United States?</p> <p><input type="radio"/> Canada?</p> <p><input type="radio"/> Europe (please specify country)? _____</p>

<p><input type="radio"/> Asia (please specify country)? _____ South America (please specify country)? _____ <input type="radio"/> Native Hawaiian or Other Pacific Islander? Caribbean (please specify country)? _____ <input type="radio"/> Other (please specify)? _____</p>
Are you a veteran of the U.S. Armed Forces?
<p><input type="radio"/> yes <input type="radio"/> no (If yes, list branch)</p> <p><input type="radio"/> U.S. Army <input type="radio"/> U.S. Air Force <input type="radio"/> U.S. Navy <input type="radio"/> U.S. Marine Corp. <input type="radio"/> U.S. National Guard <input type="radio"/> U.S. Coast Guard</p>

Education
<p>What is your highest level of education in your profession? <input type="radio"/> Diploma/Certificate</p> <p><input type="radio"/> Associate Degree <input type="radio"/> Baccalaureate Degree <input type="radio"/> Master's Degree</p>
<p>As it relates to the previous question, what is the name of the school from which you received your highest level of education?</p> <p>_____</p>
<p>As it relates to the previous question, what year did you complete your highest level of education in your profession? (yyyy) _____</p>
<p>What specialty and/or post graduate training do you have (check all that apply)?</p> <p><input type="radio"/> NBRC specialty credential</p> <p><input type="radio"/> Adult Critical Care Specialty <input type="radio"/> Certified Pulmonary Function Technologist <input type="radio"/> Certified Respiratory Therapist <input type="radio"/> Neonatal/Pediatric Respiratory Care Specialist <input type="radio"/> Registered Pulmonary Function Technologist <input type="radio"/> Registered Respiratory Therapist <input type="radio"/> Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist <input type="radio"/> I hold no NBRC credential – state licensed only.</p> <p><input type="radio"/> Other specialty credential</p> <p><input type="radio"/> Certified Asthma Educator <input type="radio"/> Advanced Life Support (ACLS, PALS, NRP, ATLS) <input type="radio"/> Registered Polysomnographic Technologist <input type="radio"/> Certified Tobacco Treatment Specialist <input type="radio"/> I hold no other specialty credential</p>
Employment Information
<p>What is your employment status? <input type="radio"/> Full time</p> <p><input type="radio"/> Part time <input type="radio"/> Intermittent</p> <p>Seeking employment in a position that requires licensure Actively working in a position that does not require my license</p>

<p>Not seeking work</p> <p>Retired</p> <p>Military leave of absence</p> <p>Current student</p>
<p>How many hours, on average, did you work per week in this profession in the last year?</p> <p><input type="radio"/> 0</p> <p><input type="radio"/> 1 - 10</p> <p><input type="radio"/> 11 - 20</p> <p><input type="radio"/> 21 - 30</p> <p><input type="radio"/> 31 - 40</p> <p><input type="radio"/> 41 - 50</p> <p><input type="radio"/> 51 or more</p>
<p>In the next three years, what best describes your employment plans?</p> <p><input type="radio"/> Maintain practice hours as is</p> <p><input type="radio"/> Reduce practice hours</p> <p><input type="radio"/> Increase practice hours</p> <p><input type="radio"/> Move to another practice location in Ohio</p> <p><input type="radio"/> Move to practice out of state</p> <p><input type="radio"/> Leave the field of [licensure type]</p> <p><input type="radio"/> Retire</p>

Practice Information
<p>At how many locations do you practice? <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three or more</p>
<p>What is the zip code of your principal practice location? _____</p>
<p>How many hours each week do you spend providing direct patient care at your principal practice location? _____</p>
<p>What is your primary specialty or area of practice at your principal practice location?</p> <p><input type="radio"/> Adult Acute Care</p> <p><input type="radio"/> Long-Term Care</p> <p><input type="radio"/> Continuing Care/Rehab (Pulmonary/Cardiac)</p> <p><input type="radio"/> Respiratory Care Management</p> <p><input type="radio"/> Diagnostics (Pulmonary Function testing/Stress testing/bronchoscopy)</p> <p><input type="radio"/> Neonatal-Pediatrics</p> <p><input type="radio"/> Education</p> <p><input type="radio"/> Sleep testing</p> <p><input type="radio"/> Home-Care</p> <p><input type="radio"/> Surface & Air Transport</p> <p><input type="radio"/> Home Medical Equipment Sales</p> <p><input type="radio"/> Research</p> <p><input type="radio"/> Other</p>
<p>What best describes the type of setting that most closely corresponds to your principal practice location?</p> <p><input type="radio"/> Acute Care Hospital</p> <p><input type="radio"/> Long-term Care Facility</p> <p><input type="radio"/> Educational Institution</p> <p><input type="radio"/> Home Care</p> <p><input type="radio"/> Physician Office</p> <p><input type="radio"/> Medical Equipment Sales</p>

<input type="radio"/> Other
Which of the following best describes your current employment arrangement at your principal practice location?
<input type="radio"/> Self-employed
<input type="radio"/> Contractual
<input type="radio"/> Salaried
<input type="radio"/> Hourly
<input type="radio"/> Temporary staffing

Languages Spoken
Are you able to communicate with patients in a language other than English?
<input type="radio"/> yes <input type="radio"/> no (If yes, list language(s))
