

# OHIO RESPIRATORY CARE PRACTITIONER EXAM APPLICATION



**OHIO RESPIRATORY CARE BOARD**  
77 S. High Street, 16th Floor  
Columbus, Ohio 43215-6108  
614.752.9218  
[www.state.oh.us/rsp](http://www.state.oh.us/rsp)

**INSTRUCTIONS:** This form is to be completed by educational waiver recipients who are applying for the State Examination Only. Please complete the following form and make one (1) copy. Mail the original application with a check or money order for the appropriate amount to the following address:

**National Board for Respiratory Care, Inc.**  
8310 Nieman Road  
Lenexa, Kansas 66214

And mail a copy of this application to the Ohio Respiratory Care Board **no later than your scheduled examination date.**

## SECTION A: Personal Information

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>	<i>Social Security No. (required)</i>			
<i>Mailing Address:</i>		<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>County</i>
<i>Home Phone No. (include area code)</i>		<i>Work Phone No. (include area code + ext.)</i>			<i>Date of Birth</i>	

- Provision of your Social Security Number is mandated for child support enforcement purposes, pursuant to Ohio Revised Code 2301.37(E) and 42 U.S.C. § 1320a-7e(b), 5 U.S.C. §552a, and 45 C.F. R. pt. 61 for potential disclosure to the Federal Department of Health and Human Services' Healthcare Integrity and Protection Data Bank (HIPDB).

## SECTION B: Your Status *(select only one)*

I qualify for an Education Waiver under Ohio law and I am applying to take the examination for the first time.  
**✓ Please enclose a check or money order for \$190.00**

I qualify for an Educational Waiver and I am a re-applicant. I have attempted the NBRC Respiratory Care Practitioner Exam \_\_\_\_\_ times. The last date was \_\_\_\_\_.  
**✓ Please enclose a check or money order for \$150.00**

## SECTION C: Test Center Location *(select only one)*

- Cleveland, Ohio  
 Columbus, Ohio

## SECTION D: Signature

I certify that I have read all sections of this application and believe that I comply with all admission policies for the Ohio Respiratory Care Practitioners Examination. The information that I have provided in this application is true and correct to the best of my knowledge. I understand that if the information provided is found to be incomplete or inaccurate, my application may be rejected and/or my examination results may be delayed, not released, or invalidated by the State of Ohio and/or the agency administering the examination.

<i>Signature of Applicant</i>	<i>Date of Signature</i>
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