NON-RESIDENT REGISTRATION FORM

OHIO RESPIRATORY CARE BOARD
77 S. High Street, 16th Floor
Columbus, Ohio 43215-6108
614.752.9218
www.state.oh.us/rsp

INSTRUCTIONS: This form is to be completed by individuals claiming a non-resident status to temporarily practice respiratory care in the state of Ohio for no more than 30 days in a year. Please complete all sections, provide required documentation and return to the above address. **NOTE:** All incomplete registrations will be returned.

SECTION A: PERSONAL INFORMATION

First Name	*Middle Name*	*Last Name*		*Social Security No. (required) **	
Address		*City*	*State*	*Zip Code*	*County*
Home Telephone No. (include Area Code)					

* Provision of your Social Security Number is mandated for child support enforcement purposes, pursuant to Ohio Revised Code 2301.373(E) and 42 U.S.C. Section 1320a-7e(b), 5 U.S.C. Section 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: QUALIFICATION REQUIREMENTS - Please choose only one

☐ I qualify for licensure in the state of Ohio based on graduation from a Board approved respiratory care program, except for the passage of the examination as required under rule 4761-5-01 of the Ohio Administrative Code. *Please provide a **FINAL OFFICIAL TRANSCRIPT**.*

☐ I hold a valid license to practice respiratory care issued by a state that has licensing requirements considered by the Board to be comparable to those of the state of Ohio and I have not been issued a license in another state that has been revoked or is currently under suspension or on probation. *Please provide a **VERIFICATION OF STATE LICENSE** form.*

SECTION C: INTENDED PLACE OF EMPLOYMENT

Employer				
Street Address	*City*	*State*	*Zip Code*	*County*
Supervisor§s Name			*Telephone No. (Include Area Code)*	

DATE:

➧ .....*Signature of Applicant*.....

RCB-016 (07/2003) This form supercedes all previous editions