**PRACTITIONER OF RESPIRATORY CARE** Date Received by Board

***Use this form if your license was suspended March 1, 2010***

***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS***

**License No.**_____

File No._____

(For Board Use Only)

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Physical Address: 1105 Terminal Way, Suite 301 Reno, NV 89502

I hereby apply for reinstatement of biennial registration and enclose the appropriate fee as indicated below:

_____ REINSTATEMENT FEE $400.00
for the biennial registration period 3/1/2010 – 2/29/2012

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. Funds")

You may pay by check, cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

**By completing the reinstatement application, you will reinstate your license to active status, which will then allow you to renew your license for the 7/1/2011 – 6/30/2013 biennial registration period. The attached renewal application submitted with applicable fees must be completed as well for you to be able to practice after 7/1/2011.* These are two separate applications, and both applications and associated fees must be submitted concurrently.**

Nevada Administrative Code (NAC) 630.525 was amended and became effective December 16, 2010 which requires that on or before July 1st of each odd-numbered year, each holder of a license to practice respiratory care shall pay the applicable fee for biennial registration to the Board and that the renewal cycle will be, thereafter July 1 through June 30 of each odd-numbered year.

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

Email address_____

Please be advised, the address you provide is viewable on the Board's website and is listed as the "public" address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

## *PLEASE NOTE:*

**NAC 630.530 (6) Renewal of license; notification of withdrawal of certification; suspension and reinstatement of license.**

**(6) If a licensee fails to pay the fee for biennial registration after it becomes due, or fails to submit proof that the licensee completed the number of contact hours of continuing education required by the Board, his license to practice respiratory therapy in this State is automatically suspended. Within 2 years after the date his license is suspended, the holder may be reinstated to practice respiratory care if he:**

**(a) pays twice the amount of the current fee for biennial registration to the Secretary-Treasurer of the Board;**

**(b) Submits proof that he or she completed the number of hours of continuing education (CE) required by the Board; and**

**(c) Is found to be in good standing and qualified pursuant to the provisions of NRS 630.277 and this chapter.**

- **YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS*.**
- **YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS* IS PUBLIC INFORMATION.**

## PLEASE TYPE OR PRINT LEGIBLY
## PLEASE PROVIDE ALL INFORMATION AS REQUESTED

Your application for Reinstatement of Registration of License requires the submission of **proof of current certification by the National Board for Respiratory Care AND twenty (20) hours of continuing professional education** as described in NAC 630.530(3)(a) **completed since March 1, 2010**. Submit your proof of completion of CE with your completed **APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS**. (See last page of this application for CE statement.)

**Indicate below your primary and secondary scope of practice specialties using the following codes:**

SCOPE OF PRACTICE SPECIALTY CODES

1 GENERAL FLOOR CARE
2 EMERGENCY / CRITICAL CARE / TRAUMA
3 SLEEP DISORDERS
4 PULMONARY FUNCTION TESTING
5 MANAGEMENT
6 PULMONARY REHABILIATION / CARDIAC REHABILITATION
7 PERINATAL / PEDIATRIC
8 HOME CARE
9 HOME MEDICAL EQUIPMENT
10 FLIGHT MEDICINE

**Code**

**Primary Specialty** ___________

**Code**

**Secondary Specialty** ___________

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## *All of the following questions refer to the time period between the date of your last renewal and the date of this application.*

## For the purposes of the following questions, these phrases or words have these meanings:

**"Medical condition"** includes physiological, mental or psychological condition or disorders.

**"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

## FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS.

1. Do you currently have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety? ______Yes ______No

2. If you currently have a medical condition which in any way impairs or limits your ability to provide respiratory care services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes ______No ______N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety? ______Yes ______No ______N/A

4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? ______Yes ______No

5 Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

_____Yes _____No

6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)

_____Yes _____No

7. Have you been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? _____Yes _____No

8. Have you had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

9. Have you voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory?

_____Yes _____No

10. Have you failed the National Board for Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration? If your answer is "yes", give details regarding how many times you failed, including dates and the reason(s) you believe you failed the examination(s). Sign your explanation. _____Yes _____No

11. Have you had your registration/certification revoked, suspended and/or limited by the National Board for Respiratory Care?

_____Yes _____No

12. Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners?

_____Yes _____No

**OTHER STATES OF CURRENT OR PREVIOUS LICENSURE**

List any and all licenses you hold or have held to practice medicine in any state, territory.

| State/Territory | License # | Date of Issuance | Dates of Practice |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(If more space is needed, attach a separate sheet.)

## CHILD SUPPORT STATEMENT

**Please place a check mark next to one of the following statements:**

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

## CERTIFICATION STATEMENT

I am currently certified by the National Board for Respiratory Care (NBRC).

**ATTACH A COPY OF PROOF OF YOUR CURRENT NBRC CERTIFICATION.**
*(YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL NOT BE RETURNED TO YOU.)*

## CONTINUING PROFESSIONAL EDUCATION (CE) STATEMENT

**If you have completed your continuing professional education, please place a check mark next to the following statement:**

_____ I completed a minimum of twenty (20) contact hours of continuing professional education (CE) as described in NAC 630.530.(3)(a), two (2) hours of which were in ethics, since March 1, 2010.

**ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING PROFESSIONAL EDUCATION (CE) HOURS.**
*(YOUR COPIES WILL NOT BE RETURNED TO YOU.)*

**FOR A CURRENT LIST OF APPROVED CONTINUING PROFESSIONAL EDUCATION SOURCES, YOU MAY VISIT OUR WEBSITE AT www.medboard.nv.gov AND CLICK THE "CONTINUING EDUCATION REQUIREMENTS FOR PRACTITIONER OF RESPIRATORY CARE LICENSE RENEWAL (NAC 630.530) BUTTON.**

## HOME ADDRESS & PHONE NUMBER *(REQUIRED)*

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

## BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION* OF LICENSE TO PROVIDE RESPIRATORY CARE SERVICES IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**

2) **I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE REJECTED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**

3) **I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE REJECTED AS INCOMPLETE IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING EDUCATION (CE); (b) THE APPROPRIATE PROOF OF CURRENT CERTIFICATION BY THE NATIONAL BOARD FOR RESPIRATORY CARE; (c) PAYMENT OF THE APPROPRIATE FEE(S); AND (d) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

_____ _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

**PRACTITIONER OF RESPIRATORY CARE**
**APPLICATION FOR REGISTRATION RENEWAL**
**FOR THE BIENNIAL REGISTRATION PERIOD 2011 – 2013**
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No._____

File No. _____

(For Board Use Only)

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

ACTIVE STATUS --------- $133.00*

Make checks payable to:
**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
(Foreign checks must indicate "U.S. Funds")

You may pay by check, cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

**This renewal application must be completed if your license was suspended on 3/1/2010 in addition to the separate reinstatement application.**

* The renewal fee has been prorated for this renewal cycle only in response to recently amended Nevada Administrative Code (NAC) 630.525 effective December 16, 2010. The amendment requires that on or before July 1st of each odd-numbered year, each holder of a license to practice respiratory care shall pay the applicable fee for biennial registration to the Board and that the renewal cycle will be, thereafter July 1 through June 30 of each odd-numbered year.

**PLEASE NOTE THE FOLLOWING IMPORTANT INSTRUCTIONS REGARDING YOUR APPLICATION:**

- Your current practitioner of respiratory care license expired on or before **JUNE 30, 2011**.
- Your license will not be renewed unless you answer **ALL** questions on this application and provide written explanations for any/all questions answered "yes".
- Your license will not be renewed unless it is accompanied with a check for the proper fee.
- Your license will not be renewed unless you attach a copy of proof of your current National Board for Respiratory Care (NBRC) certification.
- All information provided on this application is **PUBLIC** information.
- **PLEASE TYPE OR PRINT LEGIBLY**.

Please print your name and address clearly in the space provided below. Be advised that the address you indicate below is viewable on the Board website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Please note: If your name has changed, a copy of the document authorizing your legal name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City _____ County _____ State _____

Zip _____

Phone Number _____ Cell Phone Number _____

Fax Number _____ E-mail address _____

## SPECIALTIES

**Indicate below your primary and secondary scope of practice specialties using the following codes:**

SCOPE OF PRACTICE SPECIALTY CODES

1 GENERAL FLOOR CARE
2 EMERGENCY / CRITICAL CARE / TRAUMA
3 SLEEP DISORDERS
4 PULMONARY FUNCTION TESTING
5 MANAGEMENT
6 PULMONARY REHABILIATION / CARDIAC REHABILITATION
7 PERINATAL / PEDIATRIC
8 HOME CARE
9 HOME MEDICAL EQUIPMENT
10 FLIGHT MEDICINE

**PRIMARY SCOPE OF PRACTICE** [ ] Enter Code

**SECONDARY SCOPE(S) OF PRACTICE** [ ] Enter Code(S)

## QUESTIONS

**For the purposes of the following questions, these phrases or words have these meanings:**

**"Medical condition"** includes physiological, mental or psychological condition or disorder.

**"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

**Please answer all of the following questions for the time period March 1, 2010 thru present date or since the date of your last renewal.**

For all YES responses to the following questions, you must submit your written explanations on a separate sheet attached to this application.

1. Do you currently have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety? _____Yes _____No

2. If you currently have a medical condition which in any way impairs or limits your ability to provide respiratory care services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety? _____Yes _____No _____N/A

4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? _____Yes _____No

5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? _____Yes _____No

6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. _____Yes _____No

7. Have you been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? _____Yes _____No

8. Have you had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?

_____Yes _____No

9. Have you voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory in lieu of disciplinary action?

_____Yes _____No

10. Have you had your registration/certification revoked, suspended and/or limited by the National Board for Respiratory Care?

_____Yes _____No

11. Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?

_____Yes _____No

## CHILD SUPPORT

**PLEASE PLACE AN "X" NEXT TO THE STATEMENT THAT APPLIES TO YOU:**

_____ I am not subject to a court order for the support of a child;

_____ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

## HOME ADDRESS & PHONE NUMBER *(REQUIRED)*

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

**BY SIGNING BELOW, I SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.**

_____

**Signature (Stamp Unacceptable)** **Date**

# CREDIT CARD AUTHORIZATION FORM

*If mailing or faxing this page separately from the application, please mail to:*
*Nevada State Board of Medical Examiners*
*P.O. Box 7238*
*Reno, NV 89510-7238*
*or fax to:*
*775-688-2321*

***Please type or print legibly.***

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____