APPLICATION FOR LIMITED MANDATORY CERTIFICATION

KRS Chapter 314A creates a mandatory certification requirement for all persons who practice respiratory care in the Commonwealth of Kentucky. The Kentucky Board of Respiratory Care is empowered to issue the necessary credentials and oversee the practice of respiratory care in the state. A copy of the statutes is attached for your review.

Specifically KRS 314A.110 (3) sets forth that "In order for student respiratory care practitioners to be employed for compensation to provide respiratory care services, they must apply to the Board for a limited mandatory certificate which will permit them to perform respiratory care procedures (for which they have received training) under direct supervision of a respiratory therapist who holds a mandatory certificate." Attached is an application which may be completed and sent, along with the appropriate fee to the Board for processing.

Persons holding the limited mandatory certification are restricted from the performance of continuous mechanical or physiological ventilatory support, arterial puncture, and blood gas analysis. The limited mandatory certificate may be granted only to individuals **actively enrolled in an accredited program for a period not to exceed three years.**

The application contains seven sections which must be completed in order to be reviewed by the Board. The sections are as follows:

1. Personal Information. Supply all pertinent information and answer all questions. If the answer to any of the questions is "yes", attach additional information explaining this response.
2. Employment Information. Provide the appropriate information about the setting in which you propose to work.
3. Supervisory Information. Since your work must be done under the direct supervision of a credentialed individual you must list the name, certificate number, and address of your proposed supervisor.
4. Supervisor's Affidavit. This section must be signed and dated by the person listed in the above mentioned section as an agreement on their part to provide supervision.
5. Educational Information. This section is to be completed by the Program Director. If enrollment is in an out of state institution, such as California College for Health Sciences, submit verification of enrollment directly from the school.
6. Program Director's Affidavit. This section must be signed by the Program Director of the educational program in which you are enrolled.
7. Applicant's Affidavit. This section must be signed and dated by the applicant.

Additionally, those persons who have completed their educational training should use the Application for Mandatory Certification to apply for temporary permission to practice. A temporary permit may be issued, for a period of six months from graduation, to a person who has graduated from an approved educational program and is waiting to sit for the entry level examination that will be administered by the National Board for Respiratory Care or its equivalent.

The completed application should be sent along with an application fee ($10) and the limited mandatory certification fee ($40) totaling $50 to the Board at the address on the front page of the application. The fee may be paid by personal check, cashiers check, or money order payable to the KENTUCKY STATE TREASURER. Both the application fee and the limited certification fee are non-refundable.

If you have questions regarding this process, please feel free to contact the office at 859-246-2747.

Rev. 05/06

KY BOARD OF RESPIRATORY CARE
2365 Harrodsburg Rd., B 350
Lexington, KY 40504-3335

APPLICATION FOR LIMITED MANDATORY CERTIFICATE

INSTRUCTIONS:

1. Read the application and instructions carefully before filling out the application. Answer all questions. If the answer is "no" or "none", please indicate. If non-applicable, indicate N/A. If additional space is needed, attach a separate sheet.
2. Please type or print.
3. Application fees are $10 and are non-refundable. The original certification fee is $40 and is non-refundable. Checks must be payable to the KY TREASURER and remit to KBRC.

PERSONAL INFORMATION

NAME OF APPLICANT:_____
Last First Middle Initial

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

HOME ADDRESS:_____
Street, PO Box, Apt#, etc County

_____
City State Zip Code

TELEPHONE NUMBER: HOME: ( )_____ OFFICE: ( )_____

Have you ever made application for certification or licensure and failed to receive same in Kentucky or any other State?
_____Yes _____No If yes, give reason application was denied_____

Has your certification in Kentucky or any other state ever been suspended or revoked? _____Yes _____No
If yes, give reasons_____

Have you ever been convicted of a felony? _____Yes _____No If yes, what offense?_____

EMPLOYMENT INFORMATION

PLACE OF EMPLOYMENT:_____ DATE OF EMPLOYMENT:_____

ADDRESS:_____
Street, PO Box, Apt #, etc

_____
City State Zip Code

SUPERVISORY INFORMATION

NAME OF SUPERVISOR:_____ KY CERTIFICATE NUMBER:_____

SUPERVISOR'S AFFIDAVIT

I, the supervisor of the record for the above named candidate for limited mandatory certification do hereby agree to provide direct supervision for said candidate during the period this limited certificate and do acknowledge that I will be held accountable to the Board for the care given to this supervisee's patients.

If for any reason, the conditions of this arrangement are changed, I will immediately notify the Board.

Further, I do certify that my Kentucky credential as a respiratory care practitioner is current and will be maintained throughout the period of supervision.

Signature of Supervisor_____ Date_____

EDUCATIONAL INFORMATION (TO BE COMPLETED BY PROGRAM DIRECTOR)

IF ENROLLED IN AN OUT OF STATE INSTITUTION SUCH AS CALIFORNIA COLLEGE FOR HEALTH SCIENCES, SUBMIT VERIFICATION OF ENROLLMENT DIRECTLY FROM SCHOOL.

NAME OF PROGRAM DIRECTOR:_____KY CERTIFICATE NUMBER:_____

SCHOOL OR COURSE YOU ARE PRESENTLY ATTENDING:_____

ADDRESS:_____
Street, P.O. Box, Apt #, etc.

_____
City State Zip Code

EXPECTED DATE OF COMPLETION OR GRADUATION:_____

In accordance with KRS 314A.205 and Administrative Regulation 201 KAR 29:010, Section 1(2) "the applicant shall have documented competency in a minimum of six (6) of the following areas as it relates to KRS 314A.010(8)".
Please indicate, by signature, in which areas the applicant has obtained documented competency:

_____OXYGEN THERAPY

_____ASSESSMENT OF PATIENTS CARDIOPULMONARY STATUS

_____CARDIOPULMONARY RESUSCITATION

_____ETHICS OF RESPIRATORY CARE AND MEDICAL CARE

_____HUMIDITY THERAPY

_____AEROSOL THERAPY

_____AIRWAY CLEARANCE TECHNIQUES

_____CHEST PHYSIOTHERAPY

_____GAS THERAPY

_____RESPIRATORY ASSIST DEVICE (RAD)

PROGRAM DIRECTOR'S AFFIDAVIT

I, the Program Director for the named institution at which the above named candidate for limited mandatory certification is enrolled, do hereby affirm that the information provided in this section of this application is true and correct to the best of my knowledge and belief.

If for any reason the conditions of the arrangement are changed, I will immediately notify the Board.

Signature of Program Director_____Date_____

Contact Phone number_____

APPLICANT'S AFFIDAVIT

I, the candidate for limited mandatory certification do hereby affirm that the information contained in this application is true and correct to the best of my knowledge and belief.

I understand the limitations which the laws and regulations place on my activities and that by receiving a limited mandatory certificate from the Board, I am responsible for conducting my practice in accordance with the laws and regulations.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification. In addition, I agree to furnish the Board with any information which may subsequently be requested for the purpose of verifying my qualifications.

Signature of Applicant_____Date_____

DO NOT WRITE BELOW THIS LINE---------FOR BOARD AND OFFICE USE ONLY

Application Fee Receipt	Board Review Date_____
Amount $_____Date:_____	_____Approved _____Denied
Check/MO #_____	Members_____
NBRC Disciplinary Database reviewed_____	

Kentucky Board of Respiratory Care
2365 Harrodsburg Rd., Suite B350
Lexington, KY 40504-3335
Phone (859) - 246-2747 Fax (859) - 246-2750

FINANCIAL LOAN STATUS NOTICE

(Important, Please read carefully)

All applicants or licensees requesting certification and registration, must not be in default on any educational financial loans with Kentucky Higher Education Assistance Authority (KHEAA). Failure to fill out this form will result in your certification being denied by the KBRC pursuant to **KRS 164.772(3)**. A Memorandum of Understanding between KHEAA and the KBRC requires applicants for initial or renewal certification to certify to the KBRC that he or she is not in default on any educational financial loans with KHEAA.

STATEMENT OF FACT (Required by KRS 164.772)

I hereby state that I am not in arrears or default on a repayment obligation under any financial assistance program with Kentucky Higher Education Assistance Authority.

I understand that if I am in arrears or default on a repayment obligation under any financial assistance program with Kentucky Higher Education Assistance Authority, my license to practice respiratory care in the Commonwealth of Kentucky may not be issued or renewed .

_____
Signature

_____
(Print Name)

_____ _____
Date Signed *Social Security Number*

This form must be signed and returned to the Kentucky Board of Respiratory Care along with the application for license and or renewal . Your application or renewal will not be processed until this signed and dated form is received. Mailing address: (Top of page).