

**Kentucky Board of Respiratory Care
1714 Perryville Rd. Ste 200
Danville, KY 40422**

(859) 246-2747 Fax: (859) 246-2750

APPLICATION FOR REINSTATEMENT

Please type or print:

1. Name:		Social Security Number:
2. Address:		
County:		Email:
3. Work Number:		4. Home Number:
5. Name license was issued under:	License Number:	
6. Do you currently hold a license in any other state(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach copy of each license.		
7. Do you have any complaints currently pending against a license held by you in any other state(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach explanation(s).		
8. Have you been convicted of any felony or misdemeanor since the time of your initial licensing in Kentucky? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach explanation(s).		
9. Date when your Kentucky License expired?		
10. List all places of employment and dates since your license expired in Kentucky:		
11. Attach reinstatement fee of \$200.00 made payable to the Kentucky State Treasurer.		
12. Attach evidence of completion of twenty-four hours of continuing education in the past twenty-four months.		

SIGNATURE: _____ **DATE:** _____

Do Not Write Below This Line - For Board Use Only

Fee Receipt Date: _____	Approved: _____	Denied: _____
Amount: \$ _____	Board Review Date: _____	
Check/MO# _____	Members: _____	
NBRC / State License Review: _____		