Rev. 01/2020

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 license and oversee the practice of respiratory care in the state.

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.

The limited mandatory certificate may be granted **for a period not to exceed three years and only to individuals actively enrolled in an accredited program.**

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 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
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.

The completed application should be sent along with an application and Certification fee for the limited mandatory totaling $60 to the Board at the address on the front page of the application. The fee may be paid on the KBRC payment portal by going to the website at https://kbrc.ky.gov or by personal check, cashier's check, or money order payable to the KENTUCKY STATE TREASURER. The Limited Mandatory Certification fee is non-refundable.

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

KENTUCKY BOARD OF RESPIRATORY CARE
2365 Harrodsburg Rd., B350
Lexington, KY 40504-3335
Phone (859) 246-2747 Fax (859) 246-2750

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 and certification fee is $60 and is non-refundable if the application is denied. Checks must be payable to the KENTUCKY STATE TREASURER.

PERSONAL INFORMATION

NAME OF APPLICANT:_____
Last First Middle Initial

SOCIAL SECURITY NUMBER:_____DATE OF BIRTH:_____

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

_____
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 Email

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:_____ Check/MO #_____	Approved_____ Denied_____ Members_____
NBRC / State License Review _____	
_____	