Kentucky Board of Respiratory Care

2365 Harrodsburg Rd., B350
Lexington, KY 40504-3335

(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)? [ ] Yes [ ] 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)? [ ] Yes [ ] 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? [ ] Yes [ ] 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: _____