APPLICATION FOR RESPIRATORY CARE LIMITED PERMIT
INSTRUCTIONS AND CHECKLIST

Carefully read the following instructions for completing the Limited Permit application.
All requested information must be provided; failure to provide requested information may result in a delay in processing of application. Incomplete applications will be returned to applicant.

Complete applications must include the following documents:

☐ Completed application form with a 2x2 passport style color photo and notary signature.

☐ Completed Verification of Education form.

☐ Request that the following documentation be sent to the above address:
   ☐ Transcripts from any post-secondary schools or programs that you have attended and/or completed/graduated or are currently attending. When requesting transcripts, please inform each school’s registrar that the transcript must be complete and indicate the degree/certificate and date conferred in mm/dd/yyyy format [if applicable].
   ☐ Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdiction.

NOTE: All documents must be received by the Board in signed, sealed envelopes.

☐ If you hold, or have ever held, any professional license, you must request and submit a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query. To request a Self-Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or at www.npdb-hipdb.com. Include the original report with this application; make a copy for your records.

NOTE: If you do not hold and have never held any professional licenses in any other state or jurisdiction, you do not need to submit a National Practitioner Data Bank self-query.

☐ Check or money order payable to the Commonwealth of Massachusetts for $150.00. Cash or foreign currency is not accepted. The fee is non-refundable and non-transferable.

☐ Submission of the Criminal Offender Record Information Request Form (CORI).

☐ Applications must be submitted on single-sided paper.

☐ Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for a Respiratory Care Limited Permit are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.

☐ Retain a copy of the completed application for a Limited Permit for your records.
IMPORTANT INFORMATION

A Respiratory Care Limited Permit applicant/holder must notify the Board in writing of any changes in the applicant’s/permit holder’s information within thirty (30) days of their occurrence, including but not limited to any change of address and any name change.

Pursuant to 261 CMR 2.08 (1), notwithstanding the expiration date stated on the Limited Permit, the privilege of practicing respiratory care pursuant to a Limited Permit shall automatically cease on the date a Limited Permit holder is no longer matriculated in and is not a graduate of a respiratory therapy program. Failure to achieve a passing score on the NBRC CCRT examination automatically voids a Limited Permit. In this event, you must cease all practice and notify the Board immediately. The Board will take appropriate action in response to any unlicensed practice.

An application is no longer valid if requirements for Respiratory Care Limited Permit are not met within one (1) year from the date of Board receipt. All fees are non-refundable and non-transferable.

The address of record is where the Board mails correspondence. Address changes may be done online at the Board’s website www.mass.gov/dph/boards or you may obtain a form online to submit to the Board’s office.

Retain a copy of the completed application for a Limited Permit for your records. Employers may require that you provide them with a copy.

Answers to many questions may be found on the Board’s website (www.mass.gov/dph/boards). Statutes and regulations governing Respiratory Care Limited Permit holders may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.
RESPIRATORY CARE LIMITED PERMIT APPLICATION FEE - $150.00
ALL QUESTIONS MUST BE COMPLETED

1. APPLICANT NAME: ____________________________________________________________________
   Last    First             Middle

   a. MAIDEN/OTHER NAME: _______________________________________________________________
      (if applicable)   Last                                   First                                      Middle

2. ADDRESS OF RECORD:
   No.                                                Street                                                Apt. #
   ____________________________________________________________________________________
   City/Town                                State                                                                  Zip Code

3. MOST RECENT PREVIOUS ADDRESS:
   _______________________________________________________
   (Different to Address of Record)   No.                           Street                Apt. #
   ____________________________________________________________________________________
   City/Town                                  State                                     Zip Code

4. TELEPHONE NUMBER(s) Day: ______________ Evening: ____________  Cell: ___________________

5. ___/___/____       Date of Birth (mm/dd/yyyy)  Place of Birth (city/state/country)
   HEIGHT: _____ Feet _____ Inches  WEIGHT: _____ Lbs.  EYE COLOR:_____________________
   Sex: M    F  (Circle One)  MOTHER’S MAIDEN NAME: _____________________________________
   Email: _____________________________________________________________________________

6. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory): ______/_____/____/
   Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and
   forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain
   whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L.
   c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: ___________________  Receipt Number: ___________________

Limited Permit Number: _RL________  Issue Date: ___________________  Initials: ___________
7. **Respiratory Care Accredited Degree Program:**

Program and Educational Institution

<table>
<thead>
<tr>
<th>No.</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Date Matriculated: __________________ Anticipated Date of Graduation: ______/_____/______ (mm/dd/yyyy)

**Applicant must arrange for an official transcript to be mailed directly to the Board by the degree-awarding institution.**

8. **Other Post-Secondary Education:**

Name of Institution

<table>
<thead>
<tr>
<th>No.</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Degree Awarded: __________________ Date Degree Awarded: ______/_____/______ (mm/dd/yyyy)

**Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.**

9. **Other Post-Secondary Education:**

Name of Institution

<table>
<thead>
<tr>
<th>No.</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Degree Awarded: __________________ Date Degree Awarded: ______/_____/______ (mm/dd/yyyy)

**Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.**

10. **Other Post-Secondary Education:**

Name of Institution

<table>
<thead>
<tr>
<th>No.</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Degree Awarded: __________________ Date Degree Awarded: ______/_____/______ (mm/dd/yyyy)

**Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.**
VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

11. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS.

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

<table>
<thead>
<tr>
<th>Issuing State/Jurisdiction</th>
<th>Profession</th>
<th>License/Certification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>__________</td>
<td>___________________________</td>
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<tr>
<td>_________________________</td>
<td>__________</td>
<td>___________________________</td>
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<tr>
<td>_________________________</td>
<td>__________</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board.

QUESTIONS

IF YOU ANSWER “YES” TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

12. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?
   Yes ☐ No ☐

13. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?
   Yes ☐ No ☐

14. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?
   Yes ☐ No ☐

15. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?
   Yes ☐ No ☐

16. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $250 or less was imposed.
   Yes ☐ No ☐

17. Have you ever been court martialed or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?
   Yes ☐ No ☐
RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Respiratory Care any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Respiratory Care to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a limited permit to practice respiratory care, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed respiratory therapist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for Limited Permit to practice Respiratory Care shall be deemed no longer valid if requirements for a Limited Permit are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Respiratory Care to deny issuance of a Limited Permit and to suspend or revoke a Limited Permit issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _______________________________ DATE ________________

PRINT NAME _______________________________________

NOTARY NAME: ______________________________

COMMISSION EXPIRES: __________________________ [Seal]

INCLUDE A NONREFUNDABLE FEE OF $150.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

APPLICATION FOR LIMITED PERMIT
BOARD OF RESPIRATORY CARE
Revised • 2-2015

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VERIFICATION OF EDUCATION FORM
LIMITED PERMIT

Directions to Applicant: Complete the "APPLICANT SECTION" below and request that the Director of your respiratory therapy program complete and sign Page 3 of this form. Return the signed, completed form to the Board of Respiratory Care, 239 Causeway Street, Suite 500, Boston, MA 02114. The Board will return a final, signed copy to you when your application has been approved.

NOTE: This form must be updated as additional competencies are achieved. Submit updated forms to the Board of Respiratory Care within thirty (30) days of completion of additional competencies.

APPLICANT SECTION:
1. APPLICANT NAME: ____________________________________________________________________
   Last                   First                   Middle
   a. MAIDEN/OFFICIAL NAME:
      (if applicable)
      Last                                   First                                      Middle

2. ADDRESS OF RECORD: ____________________________________________________________________
   No.                  Street           Apt. #
   City/Town                                   State                                                   Zip Code

3. Telephone Number(s) Day:__________________    Evening:__________________

4. SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory): ____________________________
   Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

5. Program/School Name: __________________________
   Address: ________________________________________________
   No.           Street
   City/Town                            State                                Zip Code
   Matriculation Date: ____________________
   (mm/dd/yyyy)
I authorize the above named school to release the information requested on this form to the Board of Respiratory Care. I further authorize the Board to release information contained in this section and to request pertinent additional information in connection with the processing of this application.

Signature of Applicant: _______________________________________ Date: __________________________ (mm/dd/yyyy)

DO NOT WRITE BELOW THIS LINE - FOR BOARD OF RESPIRATORY CARE USE ONLY

Date Received: ____________________________________________
Permit Issue Date: _________________________________________
Expiration Date: __________________________________________
Permit # RL _______________________

THIS LIMITED PERMIT IS NOT VALID WITHOUT BOARD SEAL

Based on the anticipated completion date of the program you are enrolled in, your Limited Permit expires on the date listed. The expiration date of a Limited Permit may be extended by the Board, as provided in 261 CMR 2.08.

A Limited Permit shall be valid during a student’s matriculation in an accredited Respiratory Care education program. A Limited Permit shall automatically expire upon a student withdrawal or dismissal from an accredited Respiratory Care education program. Prior to the expiration of the limited permit, the Limited Permit holder must take and pass the CRT examination and provide official documentation of same to the Board, in completion of the full license application. Failure to achieve a passing score on the NBRC CCRT examination automatically voids the Limited Permit. In this case, you must cease practice and notify the Board immediately. The Board will take appropriate action in response to unlicensed practice.

A copy of the statute & regulations pertaining to Respiratory Care is available on the Board’s web site at .mass.gov/dph/ or from the State House Bookstore, Room 116, State House, Boston, MA 02133. Phone: (617) 727-2834. The statutes for Respiratory Care are Massachusetts General Laws, Chapter 13, section 11B and Chapter 112, sections 23R through 23BB. The Board regulations are 261 Code of MA Regulations, sections 2.00 through 5.00.

[Board Seal]
VERIFICATION OF EDUCATION PROGRAM SECTION: To be completed by Respiratory Therapy Program Director.
The individual named on this form has indicated that he/she is matriculated in the study of respiratory care in your program. Please complete this form and check "yes" or "no" for each of the respiratory care competencies the individual has successfully completed as of the date of this form.

NOTE: This form must be updated as additional competencies are achieved. Submit updated forms to the Board of Respiratory Care within thirty (30) days of completion.

**Limited Permit Holder Applicant Name:**
____________________________________________________________________________

Matriculation Date: _____/____/______  
(mm/dd/yyyy)

**Type of Program (check one):** ___Master’s ___ Bachelor’s ___ Associate’s ___ Certificate

**NOTE:** Applicant must be currently enrolled in a respiratory program to hold a limited permit. Applicant is in his/her ______ year ______ semester of respiratory care study.

This individual will/has complete(d) the program on: _____/_____/______.  
(mm/dd/yyyy)

Respiratory Care Duties Successfully Completed: The applicant is eligible to perform specific procedures ONLY within the duties checked "yes”. The applicant must also meet the educational program or employer's standards for these procedures in specified patient care situations.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. administration of medical gases</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. use of gas administering devices</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3. administration of humidification and aerosols</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4. administration of aerosol medications</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5. support services for mechanically ventilated patients</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>6. postural drainage</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7. bronchopulmonary hygiene</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>8. breathing exercises</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>9. respiratory rehabilitation</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>10. cardiopulmonary resuscitation</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>11. maintaining natural and artificial airways</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>12. measuring ventilatory volumes, pressures, flows</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>13. collecting specimens of blood and other materials</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>14. pulmonary function testing</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>15. hemodynamic and other related physiologic monitoring of the cardiopulmonary system</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>16. teaching patients and families respiratory care procedures</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>17. consultation for health educational and community agencies</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>18. teaching knowledge, skills attitudes of respiratory care</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

I certify that the individual named on this form has successfully completed the duties checked as "yes" and is in good academic standing in or a graduate of the program.

Program Director Name (Print): ______________________________  [ School ]
Program Director Signature: ______________________________     [ Seal ]
School Name: ______________________________
Date: ______________________________