COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
BOARD OF RESPIRATORY CARE
250 WASHINGTON STREET
BOSTON, MA 02108
800-414-0168
617-973-0800
www.mass.gov/dph/boards

VERIFICATION OF EDUCATION FORM
LIMITED PERMIT

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.

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

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: _____/_____/_____
(mm/dd/yyyy)