APPLICATION FOR RESPIRATORY THERAPY STUDENT

Completion of this application form is necessary for consideration for licensure. Disclosure of this information is voluntary; however, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure or renewal have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application may be subject to the public information laws of this state.

Please type or print. When space provided is insufficient, attach additional pages. You may reproduce these blank forms as needed. Please make sufficient copies of all forms before you begin.

1. Indicate your full legal name. If your name is different from that shown on your documentation you must submit a copy of the legal document of name change.

Full Name: _____
first middle last suffix

Other names used, including maiden name: _____

2. Include residence, mailing and e-mail address. Residence address may *not* be a Post Office Box, except qualified participants under the Safe At Home Act, K.S.A. 75-451 *et seq.* may use substitute residential and mailing addresses.

Residence Address: _____
street city county state zip

Mailing Address: _____
public information street city county state zip

E-mail: _____

3. Daytime phone number (include area code): _____

4. Identification. Disclosure of your social security number is required by federal mandates set forth in 42 U.S.C.S. § 666(a)(13). K.S.A. 74-148(a) provides that every application by an individual for a professional license shall require the applicant's social security number. K.S.A. 74-139 requires disclosure of your social security number upon request to the Kansas director of taxation. Your social security number may be provided for child support enforcement actions, to the Kansas director of taxation, for reporting disciplinary actions to the National Practitioner Data Bank-Health Integrity and Protection Data Bank (NPDB-HIPDB) as required by 45 C.F.R. §§ 61.1 *et seq.* Disclosure of your social security number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Such disclosure is for identification purposes only. Your social security number will not be released for any other purpose not permitted by law.

Date of Birth: _____ Place of Birth: _____
city state/jurisdiction country

Sex: M ☐ F ☐

Social Security/Tax ID. No: _____ NPI (National Provider Identifier): _____ NPI Not Applicable: ☐

Are you a U.S. Citizen? Y ☐ N ☐ If you answered NO, are you (check one):

A qualified alien (as defined in 8 U.S.C.A. § 1641). ☐

A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 *et seq*). ☐

An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year. ☐

A foreign national, not physcially present in the United States. ☐

Other: _____

5. List the professional school you are attending.

School Name: _____

Address: _____
street city state zip country

Start Date: _____ Anticipated Degree: _____
month year

6. List all employment/professional activity during the past five years. Account for all time and explain all gaps in professional activity. Attach an additional sheet if necessary. Include actual work addresses, not corporate headquarter's address.

I have not been employed during the past five years. ☐

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
city state mm/yy mm/yy

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
city state mm/yy mm/yy

Employer: _____ Job description/Title _____

Address: _____ Dates: From _____ To _____
city state mm/yy mm/yy

7. Recommendation by a non-family member that has known the applicant for a minimum of 2 years.

I _____ , affirms that _____
(name, please print) (name of applicant)

has been known to me for _____ year(s), and that the applicant, to the best of my knowledge is of good professional character, and not addicted to the use of alcohol or narcotic drugs.

_____ _____
signature address

_____ _____
date city, state and zip

Applicant Name: _____
(please print or type)

8. Certificate of Professional School (Post Secondary School)

It is herby certifed that _____ , is enrolled as a student in respiratory therapy at
(applicant' sname)

_____ beginning _____ with an anticipated completion
(school's name) date - mmddyy

date of _____ .
date - mmddyy

_____ _____
(signature of President, Registrar, Dean, Director of Course) date

_____
Name of School

School Seal here
(if no school seal, statement must be notarized by the school)

9. Photo.

Attach a **2"x 3" wallet size** photograph of applicant with head and shoulder areas only. The photograph must have been taken within 90 days prior to date of application. Proof photographs, negatives, copies of photographs, poor quality, photographs cut from books, newspaper articles or passport photos are **NOT** accepted.

Photo here

Applicant Name: _____
(please print or type)

10. Please answer each of the following questions by putting a check in the appropriate box. All "yes" answers MUST be thoroughly explained in detail on a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. If you are unsure of your response to a particular question, check the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. A honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check the "no" box.

(a) Yes ☐ No ☐ Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training program prior to completing the training?

(b) Yes ☐ No ☐ Have you ever had any application for any professional license refused or denied by any licensing authority?

(c) Yes ☐ No ☐ Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

(d) Yes ☐ No ☐ Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

(e) Yes ☐ No ☐ Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

(f) Yes ☐ No ☐ Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

(g) Yes ☐ No ☐ Have you ever voluntarily surrendered any professional license?

(h) Yes ☐ No ☐ Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation or had any other disciplinary action taken against any professional license you have held?

(i) Yes ☐ No ☐ Have you ever been notified or requested to appear before a licensing or disciplinary agency?

(j) Yes ☐ No ☐ To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?

(k) Yes ☐ No ☐ Has any professional association imposed any disciplinary action against you?

(l) Yes ☐ No ☐ Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

(m) Yes ☐ No ☐ Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

(n) Yes ☐ No ☐ Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

(o) Yes ☐ No ☐ Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

(p) Yes ☐ No ☐ Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

(q) Yes ☐ No ☐ Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

(r) Yes ☐ No ☐ Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

(s) Yes ☐ No ☐ Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?

(t) Yes ☐ No ☐ Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

(u) Yes ☐ No ☐ Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

(v) Yes ☐ No ☐ Have you ever been court martialed or discharged dishonorably from the armed services?

(w) Yes ☐ No ☐ Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?

(x) Yes ☐ No ☐ Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs?

(y) Yes ☐ No ☐ Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs?

Additional information, reference question letter and include date, place, reason and disposition of the matter. Attach all relevant legal documentation.

_____

_____

_____

_____

_____

_____

Applicant Name: _____
(please print or type)

11. Oath must be signed by applicant and notarized.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice as a respiratory therapist student in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years of each violation (K.S.A. 21-3805).

_____
Signature of Applicant

Sworn to before me this _____ day of

_____ 20 _____

SEAL here

_____ Notary Public

_____ Commission Expires

12. Application fee of $15.00.
Make the fee payable to: Kansas State Board of Healing Arts or charge by credit/debit card using the attached authorization form.

Applicant Name: _____
(please print or type)

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

Authorization and Release

Must be signed by applicant and notarized.

I,_____ , hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas State Board of Healing Arts or its successors any information, files or records requested by the Board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure.

_____

Signature of Applicant

Sworn to before me this _____day of

_____ 20 _____

_____ Notary Public

SEAL here

_____ Commission Expires

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GENERAL INFORMATION AND INSTRUCTIONS
Respiratory Therapy Student
Please visit http://www.ksbha.org/statutes/booklets/respiratorytherapy.pdf
for all information governing a Respiratory Therapy License.

Thank you for your interest in becoming licensed in Kansas. Please read the following information very carefully. This information is vital to the successful completion of your application. Often your questions are covered in this form. Please allow two (2) weeks after the submission of the application before contacting our office. **Do not** make a commitment to any work dates prior to being licensed.

It is highly recommended you make and keep copies, for your records, of all items submitted for review. In addition, when mailing you may want to request a delivery confirmation to confirm your application has been received at the Kansas State Board of Healing Arts (KSBHA).

One of the missions of KSBHA is public protection through effective licensure and enforcement. One way the public is safeguarded is by issuing licenses to fully qualified, competent and ethical applicants. You will be asked a series of attestation questions. A "yes" answer is not an automatic disqualification from licensure. All applicants are considered on an individual basis. You may be requested to submit information or documents in addition to the requirements mentioned herein before the application will be deemed complete to determine whether you are fit for licensure. You should know that licensure is a privilege, not a right. Failure to disclose could constitute grounds alone for denial of your application. Please avoid some of the common excuses: "My attorney told me I don't have to disclose." or I did not think the prior act had anything to do with my profession or that it was still on my record or that it happened so long ago." There is no excuse not to disclose.

Kansas Application Fees must be submitted with the application and are **NOT** refundable. Kansas application fee is $15.00. Make checks payable to KSBHA. Checks returned for any reason by the payer's financial institution must be replaced by a money order, certified check, or credit card. To pay by debt or credit card please complete the credit card authorization form.

You must submit any change of address to the Board. Please visit our website to complete the "Change of Address" form.

Portions of the application may be copied and sent to the appropriate place to be completed and mailed directly to the Kansas State Board of Healing Arts.

A permit shall be valid for a period not to exceed 24 months and shall not be extended without additional proof that the student continues to be enrolled in an approved school of respiratory therapy. The permit shall expire on the date that the student graduates from an approved school of respiratory therapy or otherwise ceases to be enrolled in an approved school of respiratory therapy.

CHECK LIST - Did you complete the following?

ALL questions answered on the application
Signature of recommendation #7
Post secondary school signature and seal #8
Head and shoulder photograph (size: **2X3** taken within 90 days of application)#9
Documentation to any “YES” answers to #10
Notarize and sign Oath #11
Notarize and sign Release Form
Completed task proficiency list
Fees

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CREDIT CARD PAYMENT AUTHORIZATION

Please enter required information, sign and date at the bottom. Mail or fax form.

☐ DISCOVER NETWORK ☐ MasterCard ☐ AMERICAN EXPRESS ☐ VISA

CARD NUMBER

Verification Code

3-4 digit non-embossed number found on the card signature panel

Expiration Date

MO / YR

Name (as it appears on the credit card):

Billing Address:

Street City State Zip

Telephone Number: - -

Payment Amount $ Purpose of Payment:

(e.g. renewal, application)

I agree to pay the above amount per the card issuer agreement.

Signature Date

Please Note: The information on this form is considered personal and not subject to disclosure under the Kansas Open Records Act.

office use only

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STATE VERIFICATION FORM

Send to all states in which a license or registration has ever been issued. Verification fees may be applicable and are the applicant's responsibility. Please contact individual boards to confirm fees. The applicant should complete the top section. The official state board should complete the bottom section and return directly to the Kansas State Board of Healing Arts.

I, hereby authorize and request the state Board of _____ having control of any documents, records and other information pertaining to me to furnish to the Kansas State Board of Healing Arts information including documents and/or records regarding charges or complaints filed against me or my license/registration; formal, informal, pending, closed or any other pertinent information.

Full Name: _____

Other Names Used (if applicable): _____ Date of Birth: ____ / ____ / ____

License or Registration No.: _____ Issue Date: ____ / ____ / ____

Profession: _____

Signature: _____ Date: _____

Full Name of licensee or registrant: _____

License or Registration No.: _____ Status: _____

Issue Date: ____ / ____ / ____ Expiration Date: ____ / ____ / ____

License Method: _____ School: _____

DISCIPLINARY ACTIONS:

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? ☐ Yes ☐ No ☐ Unable to Divulge

Have formal disciplinary proceedings been initiated against the applicant or applicant's license or registration by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Unable to

Comments _____

(SEAL)

Signature _____

Title _____

State Board of _____

Date _____

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Respiratory Therapy Student Special Permit Task Proficiency

List to be completed by the Respiratory Program

Indicate which of the following tasks the student has demonstrated proficiency in the lab and/or clinical setting. A student holding a special permit will be able to perfom only those tasks indicated below. The employer is responsible for documenting competency and providing orientation/training to the holder of the special permit. The original should be return to the Kansas State Board of Healing Arts and a copy given to the applicant to present to their employer.

Student's name: _____

(a) Yes ☐ No ☐ Patient assessment

(b) Yes ☐ No ☐ Aerosol respiratory medication administration

(c) Yes ☐ No ☐ Metered dose inhaler

(d) Yes ☐ No ☐ Small/large volume nebulizer

(e) Yes ☐ No ☐ IPPB

(f) Yes ☐ No ☐ Humidity and aerosol therapy

(g) Yes ☐ No ☐ Medical gas administration (nasal cannula, simple mask, venture mask, partial and nonrebreathing mask)

(h) Yes ☐ No ☐ Medical gas cylinders, regulators, flowmeters

(i) Yes ☐ No ☐ Chest physical

(j) Yes ☐ No ☐ Incentive spirometry

(k) Yes ☐ No ☐ PEP therapy

(l) Yes ☐ No ☐ Basic spirometry

(m) Yes ☐ No ☐ Arterial/capillary blood gas analysis (may include electrolytes)

(n) Yes ☐ No ☐ Arterial blood gas/capillary sampling

(o) Yes ☐ No ☐ Suctioning: oral

(p) Yes ☐ No ☐ Suctioning: nasal/tracheal

(q) Yes ☐ No ☐ Suctioning: ET/trach tube

(r) Yes ☐ No ☐ Pulse oximetry

(s) Yes ☐ No ☐ CPR

(t) Yes ☐ No ☐ EKG

(u) Yes ☐ No ☐ Mechanical ventilation

(v) Yes ☐ No ☐ Non-invasive ventilation: CPAP

(w) Yes ☐ No ☐ Non-invasive ventilation: BiPAP

(x) Yes ☐ No ☐ Intubation/extubation

(y) Yes ☐ No ☐ Other: _____

Name of Program: _____

_____
Signature

_____
Title

SEAL

_____
Date

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