

For Office Use Only Application fee	<input type="checkbox"/> \$90
Background check fee	<input type="checkbox"/> \$55

# Application for Respiratory Care and Polysomnography Licensure

## Iowa Department of Public Health/Bureau of Professional Licensure

**PLEASE PRINT**

**Instructions are found on page 4**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
*Last Name* *First Name and Middle Name*
3. \_\_\_\_\_  
*Mailing Address*
4. \_\_\_\_\_ 5. \_\_\_\_\_  
*City, State, Zip Code* *E-Mail Address*
6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_ -- --  
*Daytime Phone (Including Area Code)* *Date of Birth* *Social Security Number\**
9.  Male  Female 10. \_\_\_\_\_  
*Gender (optional question)* *If any of your documentation is in a name other than your current name, list the previous names of record.*

**The following questions must be answered.** If you answer "Yes" to question #11 – #16 below, (1) attach a signed letter of explanation providing the details of the incident, (2) attach a copy of any court ordered evaluations, showing completion and recommendations, and (3) attach a copy of all official court documents regarding your conviction/malpractice suit, including final disposition and/or settlement. You must answer "Yes" even when a conviction or judgment has been deferred or expunged from your record.

11. Been convicted, found guilty of or entered a plea of guilty or no contest to a felony or misdemeanor crime (Other than minor traffic violations with fines under \$500)?	Yes	No
12. Had any judgments or settlements paid on your behalf as a result of a malpractice suit or claim against you?	Yes	No
13. Been investigated by a licensing, registration, or certification authority or organization; or had a licensing, registration, or certification authority or organization institute disciplinary action against you related to your professional practice? (If the investigation or action was instituted by this licensing board you may answer "NO" to this question).	Yes	No
14. Been disciplined or sanctioned by any licensing, registration, or certification authority or organization related to your professional practice? (If this licensing board took the disciplinary action, you may answer "NO" to this question).	Yes	No
15. Been engaged in illegal or improper use of drugs or other chemical mood altering substances? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes	No

16. Are you or have you ever been licensed, registered or certified in another state?  Yes  No  
 If yes, list the two-letter abbreviation for the state(s) below.

\_\_\_\_\_

17. Do you currently hold licensure in Iowa? \_\_\_\_\_

If yes, license # \_\_\_\_\_ License Type \_\_\_\_\_

18. Are you applying for the polysomnography component of this license through work experience?  Yes  No

If yes, please submit the polysomnography experience verification form completed by the medical director for your agency.

### Respiratory Care Education

19. Have you completed an educational program for Respiratory Care?  Yes  No

20. \_\_\_\_\_  
Name of Program

21. \_\_\_\_\_  
Graduation Date

### Respiratory Exam Information

22. Have you passed a National Board Respiratory Care Exam (NBRC) national certification exam in Respiratory Care?  Yes  No

23. Certified Respiratory Therapist Exam (CRT),  Yes  No

24. Registered Respiratory Therapist Exam (RRT),  Yes  No

25. Therapist Multiple-Choice Examination?  Yes  No

### Polysomnographic Education:

26. Have you graduated from a polysomnographic educational program?  Yes  No

27. Have you earned a polysomnographic certificate from the respiratory care program?  Yes  No

28. Have you earned a polysomnographic certificate from an electroneurodiagnostic program?  Yes  No

29. \_\_\_\_\_  
Name of Program

30. \_\_\_\_\_  
Graduation Date

### Polysomnographic Exam:

31. Have you obtained a Registered Polysomnographic Technologist credential from the Board of Registered Polysomnographic Technologists?  Yes  No

32. Have you obtained a Sleep Disorders Specialist (SDS) credential from the National Board Respiratory Care (NBRC)  Yes  No

**I certify** that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I attest that I do not have a medical condition which impairs or limits my ability to practice my profession with reasonable skill and safety and understand that I must notify the Board should such a condition arise which impairs or limits my ability to practice my profession with reasonable skill and safety.

\*This information is collected pursuant to Iowa Code Chapters 252J, 261 & 272C. Failure to provide mandatory information will result in license denial. **Privacy Act Notice:** Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law.

33. \_\_\_\_\_  
**Applicant must sign here in ink** \_\_\_\_\_ **Date**

# Respiratory Care and Polysomnography Practitioner License

## Documentation Required for Licensure

- Application and fee (\$90 + \$55 (cost of the FBI and DCI background check) = \$145). **All application fees are nonrefundable.** To apply, do one of the following:
  - Create an account, apply and pay online at:  
<https://ibpllicense.iowa.gov/PublicPortal/Iowa/IBPL/common/index.jsp>, OR
  - Request an application packet and return it with a check or money order payable to the Iowa Board of Respiratory Care and Polysomnography: <http://idph.iowa.gov/Licensure/Iowa-Board-of-Respiratory-Care/Licensure/Application-Request-Form>
  
- Verification of any **one** of the following:
  - Official transcript showing completion of a polysomnography program accredited by CAAHEP, or
  - Official transcript showing completion of a respiratory care sleep add on program accredited by CoARC, or
  - Official transcript showing completion of an electroneurodiagnostic technologist educational program that is accredited by CAAHEP and proof of completion of the curriculum for a polysomnographic certificate as an extension of the electroneurodiagnostic educational program. or
  - Passing score on the Registered Polysomnographic Technologist Exam administered by the BRPT, or
  - Passing score on the sleep disorders specialist exam administered by the NBRC, or
  - Verification from the medical director of the individual's current employer that the individual has completed on-the-job training in the field of polysomnography, and is competent to perform polysomnography.
  
- Background Check Requirement – (Even if you have completed a background check as part of a previous application, a new check will be required as it is statutorily required for the polysomnography component of the dual license.) Most law enforcement agencies have fingerprint cards available upon request or you may request an application packet to be mailed to you. The application packet will include a licensure application form AND materials to complete a background check, including fingerprint cards and a waiver. To receive the correct packet, contact the Iowa Board of Respiratory Care at (515) 281-0254 or complete the following information.

Applicants will receive a packet from the Board office in the mail after submitting an online licensing application or along with the paper application (if requested). The packet includes two items that must be returned to the Board office before the license can be issued:

1. Two fingerprint cards. Take the fingerprint cards to a local law enforcement agency for completion. Submit both completed fingerprint cards to the Board office.
2. Background check waiver form. Read and sign the waiver form. Return it with the completed fingerprint cards.

**Mail the completed fingerprint cards and waiver form to:**

**Board of Respiratory Care & Polysomnography  
Bureau of Professional Licensure  
Lucas State Office Building, 5<sup>th</sup> Floor  
321 E. 12th Street  
Des Moines, Iowa 50319-0075**

**IOWA BOARD OF RESPIRATORY CARE AND POLYSOMNOGRAPHY**  
IOWA DEPARTMENT OF PUBLIC HEALTH  
LUCAS STATE OFFICE BUILDING, 5<sup>TH</sup> FLOOR  
DES MOINES, IOWA 50319-0075

**EXPERIENCE/EMPLOYMENT VERIFICATION**  
**(Must be completed by medical director)**

Applicant name: \_\_\_\_\_

The above named person has applied for Iowa licensure in Polysomnography. Please complete this form to verify the applicant's eligibility.

1. Name of Agency: \_\_\_\_\_

2. Place of Practice: \_\_\_\_\_

3. Applicant's job title at agency: \_\_\_\_\_

4. Dates of employment: \_\_\_\_\_

5. Total number of hours of paid polysomnographic work experience by applicant within the last three years under your supervision: \_\_\_\_\_

6. Brief description of applicant's practice/duties:

7. To the best of your knowledge, is the applicant competent to perform polysomnography?      Yes      No

**Medical Director Certification:**

I hereby attest that all the above information is true and correct to the best of my knowledge.

Medical Director's name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTARY

State of..... [County] of.....

Signed and sworn to (or affirmed) before me on.....(Date) by.....Name(s) of individual(s) making statement.

Signature of notarial officer.....

Title of office.....

Stamp

My commission expires:.....



## NONCRIMINAL JUSTICE APPLICANT'S RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as licensing, employment, or adoption), you have certain rights which are discussed below:

- You must be provided written notification that your fingerprints will be used to check the criminal history record of the FBI.
- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record.

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <http://www.fbi.gov/about-us/cjis/background-checks>.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)



## Waiver Agreement and Statement

For National Criminal History Record Checks  
as authorized by state legislation or federal statute

Pursuant to the Iowa User Agreement, this form must be completed and signed by every current or prospective licensee, employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a Qualified Entity (QE) under state legislation or federal statute.

I hereby authorize (**Name of QE**) Iowa Board of Respiratory Care and Polysomnography  
to submit a set of my fingerprints to the Iowa Department of Public Safety (DPS), Division of Criminal Investigation (DCI) for the purpose of accessing and reviewing Iowa and FBI national criminal history records that may pertain to me. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any Iowa and/or national criminal history record that may pertain to me to the QE with which I am or am seeking to be licensed, employed or to serve as a volunteer. Furthermore, I authorize the QE to forward this agreement to DCI upon request.

I understand that, until the criminal history record check is complete, the QE may choose to deny me unsupervised access to children, elderly or individuals with disabilities. I further understand that, if applicable, the QE may choose to deny my application or grant me a limited or restricted license until the criminal history record check is complete.

I understand that I am entitled to challenge the accuracy and completeness of any information contained in the criminal history report, if any, received on me. I understand that the procedures for obtaining a change, correction, or updating of my criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34. I may obtain a prompt determination as to the validity of my challenge before a final decision is made about my status as a licensee, employee, volunteer, contractor or subcontractor.

I **have** been convicted of a crime                       I **have not** been convicted of a crime.

If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below. Use additional paper as needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am a current or prospective (check one):     Licensee     Employee     Volunteer     Contractor/Vendor

Please complete the following information as it appears on valid photo identification:

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE QUALIFIED ENTITY:**

QE Name: Iowa Board of Respiratory Care and Polysomnography                      OCA: RESCARE

Address: Bureau of Professional Licensure, 321 E 12th Street, Des Moines, Iowa 50319

Telephone: 515-281-0254                      Fax: 515-281-3121

**This waiver must be retained at the QE for one year after the applicant is no longer relevant to the QE or one year post audit by DCI, whichever is longer. Do not send to DCI unless requested.**