

For Office Use Only Application fee	<input type="checkbox"/> \$60
Background check fee	<input type="checkbox"/> \$55

Application for Respiratory Care and Polysomnography Licensure 2016 Biennial Renewal Form

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. SINCE 04/01/2014 HAVE YOU:

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

17. 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.

18. Do you currently hold licensure in Iowa? _____

If yes, license # _____ License Type _____

19. 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

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

21. _____
Name of Program

22. _____
Graduation Date

Respiratory Exam Information

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

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

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

26. Therapist Multiple-Choice Examination? Yes No

Polysomnographic Education:

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

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

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

30. _____
Name of Program

31. _____
Graduation Date

Polysomnographic Exam:

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

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

Renewal Questions:

Mandatory Reporter

Are you employed in one of these settings?

Foster care facility, head start program, hospital, intermediate care facility, juvenile detention center, juvenile home, juvenile shelter care facility, licensed child care center, mental health center, nursing facility, registered child care home, residential care facility, state mental health institute, state training school or substance abuse program.

<input type="checkbox"/>	I am not employed in any of these settings.
<input type="checkbox"/>	I am employed in one of these settings, but I do not, in the scope of my professional practice, examine, attend, counsel, or treat dependent adults or children in Iowa.
<input type="checkbox"/>	I am employed in one of these settings and, in the scope of my professional practice, I examine, attend, counsel, or treat dependent adults and/or children in Iowa and have completed the course(s) within the last five years.
<input type="checkbox"/>	I am exempt from the requirements for mandatory training for identifying and reporting dependent adult and/or child abuse because I was on active duty in the military during this biennium; 04/01/2014 through 03/31/2016.
<input type="checkbox"/>	I am exempt from the requirements for mandatory training for identifying and reporting dependent adult and/or child abuse because I have a physical or mental disability exemption approved by the Board.

Continuing Education.

- To review the continuing education rules, go to <http://idph.iowa.gov/Licensure/Iowa-Board-of-Respiratory-Care/Continuing-Education>
- You **must** check the one statement below that applies to you.

<input type="checkbox"/>	This is my first renewal after initial licensure, continuing education isn't required.
<input type="checkbox"/>	I have completed the required 24 hours of continuing education, earned 04/01/2014 through 03/31/2016. Note: If you are reporting continuing education for the first time, you may report hours earned from the date of your initial licensure.
<input type="checkbox"/>	I am exempt from the continuing education requirements because I am licensed and reside in another state or district having continuing education requirements for my profession. I have met all continuing education requirements of that state or district for practice.
<input type="checkbox"/>	I have been granted an extension of time to fulfill the continuing education requirements or I have been granted an exemption by the board (due to a physical or mental disability or illness). My doctor and I have completed the 'Application for Continuing Education Extension/Exemption for Disability or Illness. The application has been mailed to the board office and has been approved by the Board. I have or am in the process of completing the requirements of my exemption.
<input type="checkbox"/>	I am exempt from the continuing education requirements because I was on active military duty during all or part of this continuing education biennium; 04/01/2014 through 03/31/2016.

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.

35. _____

Applicant must sign here in ink

Date

Respiratory Care and Polysomnography Practitioner License

Documentation Required for Licensure

Individuals applying for the new dual license should carefully review the requirements. If after review you wish to apply for the new dual license instead of renewing your respiratory care license, please complete an application online or mail in a completed paper application to the board office along with supporting documents by March 15th so the Board will have sufficient time to process your application before your respiratory care licensure grace period expires. Once the renewal period ends respiratory therapists will be unable to apply for dual license until January 1, 2017.

- Application and fee (\$60 + \$55 (cost of the FBI and DCI background check) = \$115). **All application fees are nonrefundable.** To apply, do one of the following:
 1. Create an account, apply and pay online at:
<https://ibpllicense.iowa.gov/PublicPortal/Iowa/IBPL/common/index.jsp>, OR
 2. 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:

- a. Official transcript showing completion of a polysomnography program accredited by CAAHEP, or
 - b. Official transcript showing completion of a respiratory care sleep add on program accredited by CoARC, or
 - c. 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
 - d. Passing score on the Registered Polysomnographic Technologist Exam administered by the BRPT, or
 - e. Passing score on the sleep disorders specialist exam administered by the NBRC, or
 - f. 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) 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, 5th 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, 5TH 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.....

Stamp

Title of office.....

My commission expires:.....



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.



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.)

Iowa Department of Public Safety
Division of Criminal Investigation