

North Dakota State Board of Respiratory Care

PO Box 2223, Bismarck, ND 58502-2223

Ph. 701-222-1564 Fax 701-224-9824

LICENSE VERIFICATION

It is the responsibility of the applicant to send this verification of licensure form to all states in which the applicant has been licensed or registered (temporary or permanent). Verification fees vary within each state. The applicant is responsible for the payment of fees.

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 North Dakota State Board of Respiratory Care information including documents, records, regarding changes or complaints filed against me, formal or informal, pending or closed, or any other pertinent information.

Signature Date License Number Date Issued

Full Name (Please print) Date of Birth Social Security Number Other names used in obtaining licensure

THIS SECTION IS TO BE COMPLETED BY AN OFFICIAL OF THE VERIFYING STATE BOARD AND RETURNED DIRECTLY TO THE NORTH DAKOTA STATE BOARD OF RESPIRATORY CARE.

Full name of licensee _____

State of: _____ License #: _____

Date of Issue: _____ Date of expiration: _____

Present status: _____ Graduate of: _____
School

LICENSE METHOD: () National Board for Respiratory Care
() State Board Exam
() Flex Plan
() Other _____

1. Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES or NO or Unable to Divulge

If yes, please attach details.

2. Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES or NO or Unable to Divulge

If yes, please attach details.

Additional Comments _____

Signature

Board Seal

Print Name

Title

Date