

**North Dakota State Board of Respiratory Care**

PO Box 2223, Bismarck, ND 58502-2223

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

[ndsbrc@aptnd.com](mailto:ndsbrc@aptnd.com) [www.ndsbrc.com](http://www.ndsbrc.com)

**APPLICATION FOR LICENSURE**

**Section A: Personal Information**

Name: \_\_\_\_\_  
Last First Middle Initial

Other Names Used: \_\_\_\_\_

Sex: M or F Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Hm. Telephone: \_\_\_\_\_ Hm. County: \_\_\_\_\_ Email: \_\_\_\_\_

Employer (If known at this time): \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip

Employer Telephone: \_\_\_\_\_ Employer County: \_\_\_\_\_

**Section B: Licensure/Background Information**

**Indicate which license you are applying for:**

\_\_\_\_\_ Registered Respiratory Therapist (\$80) \_\_\_\_\_ Certified Respiratory Therapist (\$80)

\_\_\_\_\_ Registered Polysomnographic Technologist (\$80)

**If applying for both a RRT and RPSGT license, mark both and you only submit one \$80 fee.**

**You must answer the following questions:**

1. Have you ever held a respiratory care or polysomnographer license from North Dakota or another state? YES or NO  
**If yes, what states?** \_\_\_\_\_

2. Do you presently hold a respiratory care license from another state? YES or NO  
**If yes, please complete:** State \_\_\_\_\_

License # \_\_\_\_\_ Type of License \_\_\_\_\_

Board office or name \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

3. Has your respiratory care or polysomnographer license ever been denied, suspended, or revoked in North Dakota or any other states? YES or NO

**If yes, please attach a written explanation.**

4. Have you ever been convicted for any violation of any federal, military, state or local laws (excluding non-criminal traffic violations)? YES or NO

**If yes, please attach a written explanation and a copy of the court judgment.**

**Section C: Academic Information**

**Transcript and Diploma:** You must either have your final, official transcript sent from the college or training program to the Board office or submit a copy of your diploma or certificate of completion, notarized or embossed with the school seal.

**Education Verification Form:** You must have your school complete and send the Education Verification Form directly to the Board office.

**Polysomnographer Applicants only:** If you were office-trained, list the facility in which you trained.

\_\_\_\_\_

**Section D: Examination**

You must include a copy of your NBRC or BRPT certificate or exam scores with this form or have NBRC or BRPT send verification of your successful completion of the exam directly to the Board office.

**Date of NBRC exam** \_\_\_\_\_ **Level of NBRC exam** \_\_\_\_\_

**Date of BRPT exam** \_\_\_\_\_

**Section E: Previous Employers**

Please list all institutions in which you have engaged in the practice of respiratory care, either as a student or licensed professional. If further space is necessary, please attach an additional sheet.

Facility	Address	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Section F: Affidavit**

**This section must be completed by you and a Notary Public.**

By signing this document, I am affirming that I am the person who is referred to in this application, that the statements therein are true in every respect, I have not suppressed any information that might affect this application, and that I have read and understand this affidavit.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_ County \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

My Commission expires on \_\_\_\_\_ 20 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

SEAL