

NORTH DAKOTA STATE BOARD OF RESPIRATORY CARE

APPLICATION FOR RENEWAL OF LICENSE
2026

**MAIL RENEWAL, CHECK, &
EDUCATION TO:**

**NDSBRC
2900 E Broadway Ave. Ste. 3
BISMARCK, ND 58501**

MAKE CHECKS PAYABLE TO: NDSBRC

Registered Respiratory Therapist \$80

LATE FEE \$25.00

Certified Respiratory Therapist \$80

MUST INCLUDE LATE FEE & COPIES OF CONTINUING EDUCATION IF APPLICATION AND FEE

Registered Polysomnographic Technologist \$80

ARE NOT POST MARKED ON OR BEFORE December 31, 2025!

LICENSE NO. _____

NAME _____

FIRST

MIDDLE

LAST

MAIDEN

SOCIAL SECURITY NUMBER (For verification purposes only!) _____

HOME ADDRESS _____

CITY

STATE

ZIP

COUNTY

HOME PHONE _____ WORK PHONE _____

E-MAIL _____ PLACE OF EMPLOYMENT _____

WORK ADDRESS _____

CITY

STATE

ZIP

COUNTY

****PERSONAL INFORMATION:**

1. Do you hold or have you ever held a license in another state? Yes No

If "Yes", list the state(s) _____

2. Has your respiratory care license ever been denied, suspended, or revoked in North Dakota or any other state since last time you renewed?

Yes No If "Yes", please attach a written explanation.

3. Have you been convicted of any violation of any federal, military, state or local laws (excluding minor traffic violations) since last time you renewed? Yes No If "Yes", please attach a written explanation.

SIGNATURE: I hereby affirm that I have completed my required hours of continuing education in conformance with NDCC subsection 43-42-03 (8). If the NDSBRC concludes that I have not complied with the requirements set forth in NDCC subsection 43-42-03 (8), and the NDSBRC does not grant an extension or waiver under NDAC section 105-02-01-04, I hereby agree to waive my right to an administrative hearing and appeal pursuant to NDCC ch. 28-32 and agree that the NDSBRC may issue an order taking disciplinary action against my license.

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 understood this document.

Signature _____

Date _____

CONTINUING EDUCATION REPORTING ON REVERSE SIDE!

OFFICE USE ONLY

Postmark Date _____

Date Received _____

Amount _____

Check # _____

NORTH DAKOTA STATE BOARD OF RESPIRATORY CARE

CONTINUING EDUCATION REQUIREMENTS

| Category | CEU Hours | CEU Date | Subject/Content/Activity | Sponsor/Educator/Institution | Provider Number |
|-----------------|------------------|-----------------|---------------------------------|-------------------------------------|------------------------|
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CEU Categories/Limits

This criterion is to be used for all categories of continuing education activities you have attended. A minimum of 10 continuing education hours is required for renewal.

NOTE: ALL LECTURES ATTENDED OR GIVEN MUST HAVE A PROVIDER NUMBER.

Category 1 – Participation in an educational activity directly related to respiratory therapy, pulmonary function technology, or polysomnography which includes any one of the following: lecture, panel, workshop, seminar, symposium, or distance education.

Category 2 – Retake and pass the respective examination for the highest credential held.

Category 3 – Pass a credentialing examination not previously completed.

**N.D.Admin. Code 105-02-01-04, “Continuing education courses must relate to or increase the professional competence of the attendee. This determination will be made by the board through approval of requested courses. The board has the authority to accept programs sponsored by a local, state, regional, national, international, scientific, or professional organization appropriate to provide continuing education (i.e., AARC, NDSRC, AMA, ALA, AHA, AASM, AAST, BRPT, ASET, etc.)