Government of the District of Columbia

HEALTH REGULATION AND LICENSING ADMINISTRATION

RENEWAL APPLICATION FOR RESPIRATORY CARE

LICENSEES MAY RENEW UNTIL: JANUARY 31, 2017

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. **False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to *DC Official Code 22-2405*. If you have any questions, call HRLA Customer Service at 1-877-672-2174 Monday through Friday, 8:15AM to 4:40PM EST.**

Please Note: Please refer to application instructions before completing this form.

SECTION 1. LICENSEE INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

____/_____/_____ _____ _____ _____ - _____ - _____

Date of Birth **Place of Birth: State/Providence/Territory** **Country if not USA** **Social Security Number**

Preferred Mailing address:

_____ _____ _____ _____

Street Address **City** **State** **Zip Code**

Phone Number:_____ **Fax Number:**_____ **EMAIL ADDRESS:** _____

SECTION 2. SPECIAL INSTRUCTIONS

- **Your license expires January 31, 2017**
- **Renewal applications submitted after January 31st will require an $85 late fee**
- **If you are unable to renew your license by January 31st or within the 60-day late renewal period, you will then be required to apply for reinstatement of your license.**
- **You may reinstate your license in the District within 5 years of the expiration date of your license. Once the 5-year reinstatement period has ended, you must meet the Board's requirements to reapply.**

CONTINUING EDUCATION REQUIREMENT: Respiratory Therapists must have a total of sixteen **(16) hours of approved continuing education, and three (3) of the sixteen (16) hours must be in ethics. No more than eight (8) CEUs may be accepted in any renewal period for approved independent home studies and distance learning continuing education activities. The credits must be for classes taken between February 1, 2015 and January 31, 2017.**

Submission of CE hours is not required for first- time renewal applicants. DO NOT send documentation verifying your compliance with CE requirement unless asked to do so by the Board. The Board will perform a CE audit following the 2017 renewal period. Documentation mailed to the Board will not be returned.

PHOTOS WILL NOT BE REQUIRED: If you do not currently have a picture on your pocket license, submit two (2) identical, recent passport-sized photographs. On the back of the photos write your full name and either your license number or Social Security Number.

ONLINE RENEWAL INSTRUCTIONS: To renew your license online go to: http://doh.dc.gov/service/health-professionals. Enter your Social Security # and Last Name, then go to the next screen and enter your User ID and Password or enter User ID/Password that you established during the 2015 renewal.

Be sure to keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify your professional board of any address change within 30 days of the change. You may send address changes to the address below. This will help ensure that you receive your next **renewal notice in a timely manner.**

SECTION 3. LICENSE RENEWAL AND FEES- Select the type of action you wish to take for your license.

Please check the appropriate box (es)	**Fee**	
A. ☐ Renew	$169.00	_____.00
B. ☐ Cancel * (see notes)	$0.00	_____.00
C. ☐ Paid Inactive	$169.00	_____.00
D. ☐ Reactivate (Paid inactive License)	$34.00	_____.00
E. ☐ Late fee (if received after due date)	$85.00	_____.00
F. ☐ Deceased	$0.00	_____.00
G. ☐ Duplicate License	$34.00	_____.00

TOTAL ENCLOSED $_____.0

*Cancelled license. Sign and return this renewal application. You may not practice in the District of Columbia until you re-apply as a new license applicant and are approved by the DC Health Regulations and Licensing Administration for a new license. Upon approval, you will be issued a new license number.

**Deceased: Return the application to the address above along with a death certificate or notarized letter indicating that the licensee is deceased.

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SECTION 4. SCREENING QUESTIONS

Please answer questions 1 through 13 by placing X in the appropriate boxes. If you answer "YES" to any of the screening questions below, you must provide complete information and details on a separate sheet of paper, including copies of all relevant court or supporting documents and attach it to this form.

1.	Since your last application, have you been arrested, convicted or charged for a felony or misdemeanor including DUIs, OWIs, or DWIs (other than minor traffic violations for which a fine or ticket is the maximum penalty)?	Yes ☐ No ☐
2.	Since your last application: (1) Have you withdrawn an application for licensure/ certification/ registration to practice any health profession in any jurisdiction? (2) Has any authority, health facility or peer review board taken action against any of your health profession licenses or privileges (including imposing a fine, sanctions, censure or reprimand, probation, imposition of restrictions, suspension or revocation)? (3) Have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority, health facility or peer review board informed you of any pending charge(s) or investigation(s)?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
3.	Since your last application, have you been diagnosed with a physical or mental condition, including alcohol or drug abuse, that currently impairs your ability to practice your profession or that could affect your performance or impact your ability to perform your professional duties?	Yes ☐ No ☐
4.	Are you currently being treated or have you been treated for a physical or mental condition, including alcohol or drug abuse, that, but for the treatment, could impair your ability to practice your profession?	Yes ☐ No ☐
5.	Since your last application, have you surrendered a license, certification, or registration to practice any health profession in any jurisdiction?	Yes ☐ No ☐
6.	Since your last application, have you been terminated, asked to resign, or resigned in lieu of being terminated from employment or a clinical training/fellowship program for any health profession?	Yes ☐ No ☐
7.	Since your last application, have you been found by a court to be legally incompetent to practice or by a medical professional to be impaired to practice?	Yes ☐ No ☐
8.	Since your last application, have you been diagnosed or treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	Yes ☐ No ☐
9.	Since your last application, has any authority, health facility or peer review board taken action against any health care facility or agency for which you have an ownership interest in, or serve as manager or director for (including imposing a fine, sanctions, censure or reprimand, probation, imposition of restrictions, suspension or revocation)?	Yes ☐ No ☐
10.	Since your last application, have you been a defendant or respondent to a claim for damages or malpractice action?	Yes ☐ No ☐
11.	Will you be mailing in name change documentation for this renewal?	Yes ☐ No ☐
12.	I certify that I have completed a total of ten (16) hours of approved continuing education. Three (3) of these sixteen (3) hours are in ethics. I certify that no more than eight (8) of the total sixteen (16) hours of continuing education are for distance learning or online courses. I understand that I may be required to document my continued education by the Board via a future audit. No CEUs are required for first-time renewal. If this applies to you, select "Yes". If you are answering "No" to this question, send an explanation and supporting documents.	Yes ☐ No ☐
13.	Do you currently practice your profession in the District of Columbia? (if you answer "yes" to this question, you do not need to submit any supporting documents)	Yes ☐ No ☐

FOR ALL "YES" ANSWERS, SUPPORTING DOCUMENTS MUST BE SUBMITTED.

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SECTION 6. PAYMENT/MAILING INFORMATION

Make **CHECK** or **MONEY ORDER** payable to **DC TREASURER**:

A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

MAIL YOUR APPLICATION PACKAGE AND CHECK TO:

Health Professional Licensing Administration-
Board of Respiratory Care – Processing Center
899 North Capitol Street, NE First Floor
Washington, DC 20002
http://doh.dc.gov/service/health-professionals

SECTION 7. CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 8*** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 9*** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 2, Chapter 18*** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to ***D.C. Official Code Title 50, Chapter 23*** (Traffic Adjudication)

Yes ☐ **No** ☐

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (***D.C. Law 11-118, D.C. Code §47-2861 et seq.***).

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that making a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____ _____ _____

LICENSEE SIGNATURE ***PRINT NAME*** ***DATE***

***PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF RESPIRATORY CARE AND RETAIN A COPY FOR YOUR FILES.**