**L**ouisiana **S**tate **B**oard of **M**edical **E**xaminers

630 Camp Street, New Orleans, LA 70130

(504) 568-6820

**Respiratory Therapist**

**Initial Licensure Application**

**READ CAREFULLY AND TAKE NOTICE:** This application and any subsequently issued license, permit, certificate, or other authority to practice in the State of Louisiana are subject to all Louisiana laws and administrative rules governing the practice of medicine and allied health. A copy of the laws and rules can be found on the LSBME website. All applicants are hereby PLACED ON NOTICE that they are responsible for knowing the laws and rules and for complying with them. By submitting this application, you expressly acknowledge and agree that you are responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which you are applying.

**Check**

Initial Louisiana License

Temporary License - **For New Graduates Only / NBRC Certified Applicants Not Eligible**

Reinstatement/Re-Licensure

**FILL IN ONLINE PRIOR TO PRINTING**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: First | | | | Middle | | Last | | | | Suffix (Jr, Sr) |
| List all names under which you have ever been known: | | | | | | | | | | |
| Social Security Number | | | Driver’s License # and Issuing State | | | | | E-mail Address | | |
| Marital Status | | | Spouse’s Full Name | | | | | Cell Phone # | | |
| Sex | Height | Weight | | Eyes | Hair | | Race | | Physical Marks | |

**ADDRESSES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Home Address  (mailing address) | Street & Number | | | City | State |
| Zip | Parish (if in LA) | | Telephone (area code) |  |
| Preferred Mailing  (if other than above) | Street & Number | | | City | State |
| Zip | | Parish (if in LA) | Telephone (area code) |  |
| Business Address  (this is the public  address and will  be posted on the  LSBME website) | Street & Number | | | City | State |
| Zip | | Parish (if in LA) | Telephone (area code) |  |

**BIRTH/LEGAL AUTHORITY TO WORK IN THE U.S.**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth | Place of Birth | | Are you a U.S. citizen? |
| If not a native born U.S. citizen, provide the following information: | | | |
| If naturalized: Certificate number | | INS number | |
| Petition number | Date issued | District court through which issued | |
| If immigrant: Type of Visa | | | |

**MILITARY SERVICE**

|  |  |  |  |
| --- | --- | --- | --- |
| U.S. Active Duty  Yes No | Branch | Dates Served | Type of Discharge |

**EDUCATION** Attach a separate page if necessary

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| College/University | | | College/University | | |
| City, State | | | City, State | | |
| Mo/Yr Started | Mo/Yr Ended | Degree Earned | Mo/Yr Started | Mo/Yr Ended | Degree Earned |

**WORK HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Account for all time not listed above from graduation date of professional school to present (include any periods of unemployment). | | | | |
| From  Month/Year | To  Month/Year | Location  City/State | Employer | Specialty/Activity |
|  |  |  |  |  |
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**CRT CERTIFICATION**

|  |  |  |
| --- | --- | --- |
| List date and result of each CRT exam attempt. Failures must be disclosed. Louisiana has a 4 attempt limit for Respiratory Therapists. | | |
| Date | Result - Pass/Fail | Expected exam date (if recent graduate) |
|  |  |  |
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**LOUISIANA LICENSES**

|  |
| --- |
| Have you ever held a healthcare related license in the State of Louisiana? Yes No. |
| If yes, what type of license  License # |

**OTHER STATE LICENSES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever held a healthcare related license, permit, or certification, permanent or temporary, in another state? Yes No | | | | |
| If yes, provide information listed below. Verification of each health care related license is required. | | | | |
| State | Type of License | License # | Issue Date | Expiration Date |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Printed Name:  Social Security #:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this document, I certify that all information provided is truthful and authentic.

What is your preferred method of written communication: E-Mail Address Mailing Address

**By submitting this application, I expressly acknowledge that I understand and agree I am responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which I am applying. A copy of which are available for my review on the LSBME website.** [**CLICK HERE TO READ THE RULES BY SELECTING YOUR LICENSE CATEGORY**](https://www.lsbme.la.gov/licensure/rules)**.**