Specialty Credentialing Examination Application

1. EXAMINATION INFORMATION

Check the examination for which you are applying:

- ☐ Neonatal/Pediatric Specialty
- ☐ Sleep Disorders Specialty
- ☐ Adult Critical Care Specialty
- ☐ Pulmonary Function Technologist (PFT)

Examination Fees and Payment Information

Enclose applicable examination fee or completed credit card information. Make check or money order payable to the NBRC and enclose with this application. (Do not send cash. A $25 non-refundable processing fee will be charged for any declined credit card or returned check.)

	New Applicant Fee	Reapplicant Fee	Voluntary Recredentialing Fee Active	Inactive
Neonatal/Pediatric	☐ $250	☐ $220	☐ $75	☐ $220
Sleep Disorders	☐ $300	☐ $250	☐ $75	☐ $250
Adult Critical Care	☐ $300	☐ $250	☐ $75	☐ $250
PFT	☐ $200	☐ $170	☐ $75	☐ $170

☐ Expired Certification Application Fee – (check if applicable)
A one-time compliance fee of $150 is required when testing to reinstate a previously held credential that has since expired.

☐ International Assessment Center Fee – $150 (check if applicable)
Refer to the NBRC Candidate Handbook for information about international examinations.

TOTAL: _____

☐ CHECK or MONEY ORDER enclosed

☐ CREDIT CARD:
☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

I agree to pay above amount according to card issuer agreement.

Card Number _____ Expiration Date _____

Name as it appears on card _____

Signature _____

Do you have a disability that requires special accommodations during testing? ☐ Yes ☐ No

If yes, complete the REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS form in the NBRC Candidate Handbook and enclose it with your application.

2. PERSONAL INFORMATION

Social Security Number _____ Gender (Male/Female) _____

Name (Last, First, Middle Initial, Former Name) _____

Mailing Address (Street Address) _____

Mailing Address (City, State, Zip/Postal Code, Country) _____

Home Telephone Number _____ Work Telephone Number _____

Date of Birth (MM/DD/YYYY) _____

Email Address _____

3. ELIGIBILITY STATUS (CHECK ONLY ONE BOX)

☐ I am applying as a ***new applicant*** (provide your eligibility status information in the respective examination box(es) that follow).

☐ I am applying as a ***reapplicant***. Reapplicants are not required to provide any further eligibility status information.

☐ I am applying to retake an examination to **comply with CCP requirements:**

- ☐ My credential has not yet expired.
- ☐ My credential has already expired. A one-time compliance fee of $150 and new applicant fee applies.

☐ I am applying for voluntary ***recredentialing***. (See Candidate Handbook for details.)

A. Neonatal/Pediatric Specialty Examination Eligibility – For *New* Applicants Only (check only one box)

☐ I am an RRT.

☐ I have held a valid CRT for at least one year.

B. Sleep Disorders Specialty Examination Eligibility – For *New* Applicants Only (check only one box)

☐ I am a CRT or RRT having completed a CoARC or CAAHEP accredited respiratory therapy education program including a sleep add-on track.

☐ I have held a valid RRT for at least three months.

☐ I have held a valid CRT for at least six months.

C. Adult Critical Care Specialty Examination Eligibility – For *New* Applicants Only

☐ I have held a valid RRT for at least one year.

D. PFT Examination Eligibility – For *New* Applicants Only (check only one box)

☐ I have a minimum of an associate degree from an accredited respiratory therapy education program.

☐ I am a Certified Respiratory Therapist (CRT) credentialed by the NBRC.

☐ I am a Registered Respiratory Therapist (RRT) credentialed by the NBRC.

☐ I have completed 62 semester hours of college credit from a college or university accredited by its regional association or its equivalent, including college credit level courses in biology, chemistry, and mathematics. A minimum of six months of clinical experience* in the field of pulmonary function technology under the direction of a Medical Director of a pulmonary function laboratory or a special care area is also required prior to applying for the examination.

☐ I am a CPFT.

* Individuals certified (CRT) prior to January 1, 1983, are required to complete only three years of clinical experience. Individuals with a baccalaureate degree in an area other than respiratory care are required to complete only two years of experience. See the Candidate Handbook for all clinical experience requirements.

4. A. EDUCATION INFORMATION

(PFT and Sleep Disorders Specialty <u>New</u> Applicants Only)

Provide the information requested about the accredited sleep add-on track (Sleep Disorders applicants only) or pulmonary function technology (PFT applicants only) program from which you received an associate degree enabling you to qualify for this examination.

Program Name and Location (city, state) _____

Program CoARC Number _____

Date of Entrance to the Program _____ Date of Graduation _____

Specialty Credentialing Examination Application, continued

4. EDUCATION INFORMATION, *continued*

B. For PFT New Applicants Only:

Other Education – where you obtained at least 62 semester hours of college credit.

☐ I have enclosed my transcripts.

☐ My transcripts will be forwarded by my college or university.

University or College	Attendance Dates (MM/YYYY – MM/YYYY)	Graduation Date (MM/YYYY)	Type of Degree

Please list the courses shown on your transcripts that reflect completion of the basic science and mathematics courses required under the applicable PFT admission route.

	Course No.	Course Title
Biology		
Chemistry		
Mathematics		

5. VERIFICATION OF CLINICAL EXPERIENCE

(PFT New Applicants only)

This section must be completed if you were required to provide employment information in the previous section. Your Medical Director must verify your clinical experience by signing below.

MEDICAL DIRECTORS PLEASE NOTE: Do not sign this statement unless all previous sections of this application have been fully completed. (Facsimile signatures are not accepted.)

I am the Medical Director of a respiratory care or special care area as defined in the NBRC Candidate Handbook.

I hereby certify that I have personal knowledge that this candidate has completed the clinical experience indicated on this application. It is my belief that this candidate meets all clinical experience requirements for eligibility to take the examination for which he or she is applying.

Medical Director's Name (PLEASE PRINT) Specialty Area (if applicable)

Medical Director's Signature State License Number/State in which license is held

6. EMPLOYMENT INFORMATION

(PFT New Applicants only)

PFT Applicants: Complete this section ONLY if you are applying as an individual with 62 semester hours of college credit and a minimum of six months of pulmonary function technology experience.

Present Employment Employment Date: ____ / ____ / _____ (MM / DD / YYYY)

Your Title or Position

Name of Hospital or Organization

Street Address

City State Zip

Supervisor Medical Director

Previous Employment (DO NOT LIST PRESENT EMPLOYER)

List previous employer below. If you need additional space to verify other employment pertinent to your eligibility, please include an additional page.

Employment Date: From: ____ / ____ / _____ (MM / DD / YYYY) To: ____ / ____ / _____ (MM / DD / YYYY)

Your Title or Position

Name of Hospital or Organization

Street Address

City State Zip

Supervisor Medical Director

7. SIGNATURE

I certify that I have read the NBRC Candidate Handbook, including the Judicial & Ethics policies, and believe that I comply with all of the admission policies for the examination for which I am applying. I certify that the information I have submitted in this application and the enclosed documents are complete and correct to the best of my knowledge and belief. I understand that, if the information I have submitted is found to be incomplete or inaccurate, my application may be rejected or my examination results may be delayed, not released or invalidated by the NBRC. I acknowledge and agree that the NBRC may release information about my examination scores and credentialed status to state agencies in those states which regulate the practice of respiratory care, accredited respiratory care education programs and the Commission on Accreditation for Respiratory Care (CoARC).

I certify that I have read the policy on inactivation of eligibility records in the NBRC Candidate Handbook and acknowledge that allowing my file for a respective examination to become inactivated will result in my having to submit a new application, document my eligibility in compliance with the then current admissions requirements and pay the new applicant fee. Further, I understand I am responsible for notifying the NBRC of any change in my mailing address to receive official notices regarding my credentials issued by the NBRC. The NBRC shall not be responsible for non-receipt of notices due to my failure to provide a current mailing address.

Name (please print)

Signature Date