Specialty Credentialing Examination Application

1. 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 Cell Phone Number **(Required)**

Date of Birth (MM/DD/YYYY)

Email Address **(Required)**

2. EXAMINATION INFORMATION

Examination Fees and Payment Information

Do not submit payment with this application. If your application is accepted, you will receive an email with instructions to submit your payment. Refer to the Candidate Handbook for a current list of examination fees.

Special Testing Accommodations

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 Candidate Handbook and enclose it with your application. **If you have not previously been provided accommodations for an NBRC examination, you must complete and submit the Request for Special Examination Accommodations form PRIOR to applying and making payment.** If the form is not received prior to making payment and scheduling a testing appointment, approved accommodations will not be provided for your scheduled examination.

3. ELIGIBILITY STATUS (CHECK ONLY ONE BOX)

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

☐ I am applying as a **repeat applicant**. Repeat applicants are not required to provide eligibility information.

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

- ☐ My credential has not expired.
- ☐ My credential has expired. New applicant fee applies.

☐ ***Neonatal/Pediatric Specialty Examination Eligibility – New Applicant Only (check only one box)***

- ☐ I am an RRT

☐ ***Sleep Disorders Specialty Examination Eligibility – New Applicant Only (check only one box)***

- ☐ I am a CRT or RRT and completed a CoARC or CAAHEP accredited respiratory therapy education program including a sleep add-on track.
- ☐ I have been an RRT for at least three months.
- ☐ I have been a CRT for at least six months.

☐ ***Adult Critical Care Specialty Examination Eligibility***

- ☐ I have been an RRT for at least one year.

☐ ***PFT Examination Eligibility – (check only one box)***

- ☐ I have a minimum of an associate degree from an accredited respiratory therapy education program.
- ☐ I am a CRT, RRT or CPFT.
- ☐ I have completed 62 semester hours of college credit from an accredited college or university, including college credit level courses in biology and mathematics.

☐ ***Asthma Educator Specialty Examination Eligibility – New Applicant Only (check only one box)***

1. I have a current, active, unrestricted license or credential from the United States in one of the following:

- ☐ Physicians (MD, DO)
- ☐ Physician Assistants (PA-C)
- ☐ Nurses (RN, LPN, NP)
- ☐ Respiratory Therapists (RRT, CRT)
- ☐ Pulmonary Function Technologists (CPFT, RPFT)
- ☐ Pharmacists (RPh)
- ☐ Social Workers (CSW)
- ☐ Health Educators (CHES)
- ☐ Physical Therapists (PT)
- ☐ Occupational Therapists (OT)
- ☐ Emergency Medical Technicians (EMT, AEMT)
- ☐ Paramedics
- ☐ Speech-Language Pathologists (CCC-SLP)

or

2. I have a minimum of 1,000 hours of direct patient asthma education, counseling or coordinating services prior to applying for the examination.

Specialty Credentialing Examination Application, continued

4. EDUCATION INFORMATION

A. (PFT and Sleep Disorders Specialty New Applicant Only)

Provide the information requested about the accredited sleep add-on track or pulmonary function technology 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

B. PFT New Applicant 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

5. EMPLOYMENT INFORMATION

(AE-C New Applicants only)

Complete ONLY if applying with 1,000 hours of 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: ____ / ____ / _____ To: ____ / ____ / _____
MM DD YYYY MM DD YYYY

Your Title or Position

Name of Hospital or Organization

Street Address

City | State | Zip

Supervisor | Medical Director

6. VERIFICATION OF 1,000 ASTHMA CLINICAL HOURS

(AE-C New Applicant only)

Complete this section ONLY if you are applying as an individual with 1,000 hours of direct patient asthma education, counseling or coordinating services. *I hereby certify that I have personal knowledge that this candidate has completed the experience indicated on this application. It is my belief that this candidate meets all experience requirements for eligibility to take the examination for which he or she is applying.*

Supervisor's Name (PLEASE PRINT)

Supervisor's Signature | Supervisor's Phone Number

7. SIGNATURE

I certify that I have read the NBRC Candidate Handbook 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 attest that the following are true:

- I understand that I have an assigned eligibility period and failure to schedule an examination appointment within the assigned period will result in expiration of the application and forfeiture of examination fees.
- I understand the examination restrictions and penalties for misconduct during testing.
- I understand my activity during testing will be monitored.
- I understand that all NBRC examination content is copyrighted intellectual property and misuse of examination content will subject me to civil and/or criminal penalties.
- I understand the Judicial and Ethics Policies of the NBRC.
- I agree that the NBRC may release information about my credentialed status to state agencies that regulate the practice of respiratory care, accredited respiratory care education programs, and the Commission on Accreditation for Respiratory Care (CoARC).
- I acknowledge that being randomly selected for a graduation or CEU audit will require me to provide official transcripts and/or copies of my CEU documentation.
- I understand that the email address I provide with my application will be used to provide notifications about the status of my application and/or credential.
- I understand that I am responsible for notifying the NBRC of any change in my mailing and/or email address, and the NBRC shall not be held responsible for non-receipt of official notices due to my failure to provide a current mailing and/or email address.

Name (please print)

Signature | Date