

Specialty Credentialing Examination Application

The National Board for Respiratory Care®	1 1
1. PERSONAL INFORMATION	□ Neonatal/Pediatric Specialty Examination Eligibility - <u>New Applicant Only (check only one box)</u>
Social Security Number Gender (Male/Female)	☐ I am an RRT
Name (Last, First, Middle Initial, Former Name)	☐ Sleep Disorders Specialty Examination Eligibility -
Mailing Address (Street Address)	New Applicant Only (check only one box) I am a CRT or RRT and completed a CoARC or CAAHEP
Mailing Address (City, State, Zip/Postal Code, Country)	accredited respiratory therapy education program including a sleep add-on track.
Home Telephone Number Cell Phone Number (Required)	☐ I have been an RRT for at least three months.
Date of Birth (MM/DD/YYYY)	☐ I have been a CRT for at least six months.
Email Address (Required)	☐ Adult Critical Care Specialty Examination Eligibility
	☐ I have been an RRT for at least one year.
2. EXAMINATION INFORMATION Examination Fees and Payment Information	☐ PFT Examination Eligibility – (check only one box)
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	☐ I have a minimum of an associate degree from an accredited respiratory therapy education program.
charged for any declined credit card or returned check.) First-Attempt Repeat-Attempt	☐ I am a CRT, RRT or CPFT.
Fee Fee	☐ I have completed 62 semester hours of college
Neonatal/Pediatric □ \$250 □ \$220 Sleep Disorders □ \$300 □ \$250	credit from an accredited college or university accredited,
Adult Critical Care ☐ \$300 ☐ \$250	including college credit level courses in biology and mathematics.
PFT ☐ \$200 ☐ \$170 Asthma Educator ☐ \$350 ☐ \$250	☐ Asthma Educator Specialty Examination Eligibility -
/ Stillid Educator - \$550	New Applicant Only (check only one box)
☐ CHECK or MONEY ORDER enclosed	1. I have a current, active, unrestricted license or credential
☐ CREDIT CARD: ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover	from the United States in one of the following (include copy):
I agree to pay above amount according to card issuer agreement.	☐ Physicians (MD, DO)
Card Number Expiration Date	☐ Physician Assistants (PA-C)
Name as it appears on card CVV Code	☐ Nurses (RN, LPN, NP)
Signature	☐ Respiratory Therapists (RRT, CRT)
Do you have a disability that requires special accommodations during	☐ Pulmonary Function Technologists (CPFT, RPFT)
testing?	☐ Pharmacists (RPh)
If yes, complete the REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS form in the NBRC Candidate Handbook and enclose it with your application.	☐ Social Workers (CSW)
	☐ Health Educators (CHES)
	☐ Physical Therapists (PT)
	☐ Occupational Therapists (OT)
a FUGIBILITY STATUS (SUFFER SUFFER SU	☐ Emergency Medical Technicians (EMT, AEMT)
3. ELIGIBILITY STATUS (CHECK ONLY ONE BOX)	☐ Paramedics
☐ I am applying as a first-time applicant (provide your eligibility status information in the respective examination box(es) that follow).	or
☐ I am applying as a repeat applicant . Repeat applicants are not required to provide eligibility information.	2. I have a minimum of 1,000 hours of direct patient asthma education, counseling or coordinating services prior to
☐ I am applying to retake an examination to comply with CMP requirements:	applying for the examination.
My credential has not expired.My credential has expired. New applicant fee applies.	

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Specialty Credentialing Exam	nination Application, continued
4. EDUCATION INFORMATION A. (PFT and Sleep Disorders Specialty New Applicant Only)	6. VERIFICATION OF 1,000 ASTHMA CLINICAL HOURS (AE-C 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)	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.
Program CoARC Number	Supervisor's Name (PLEASE PRINT)
Date of Entrance to the Program Date of Graduation	Supervisor's Signature Supervisor's Phone Number
4. EDUCATION INFORMATION, continued 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 Graduation Date Type of (MM/YYYY – MM/YYYY) (MM/YYYY) Degree	
5. EMPLOYMENT INFORMATION (PFT and AE-C New Applicants only) PFT: Complete this section ONLY if applying with 62 semester hours of college credit and a minimum of six months of pulmonary function technology experience.	
AE-C: 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: / / / / / / / _	

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Zip

State

Medical Director

Your Title or Position

Street Address

Supervisor

City

Name of Hospital or Organization

Specialty Credentialing Examination Application, continued

8. SIGNATURE

I certify that I have read the <u>NBRC Candidate Handbook</u> 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 90 calendar days from the day my application is accepted to take the examination, and failure to schedule an examination appointment within the 90-day 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 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 <u>Judicial and Ethics Policies</u> 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