Bureau of Professional Licensing
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# CERTIFICATION OF COMPLETION OF A RESPIRATORY THERAPY PROGRAM

Authority: 1978 PA 368

This form must be submitted directly to this office by your educational institution. If this form is submitted by the applicant, it will not be accepted.

| Applicant's Name (First, Middle, Last) | | Date of Birth |
|---|---|---|
| Address | | |
| City | State | Zip Code |
| Telephone Number | Email Address | |

| Name of Educational Institution | | |
|---|---|---|
| Address of Educational Institution | | |
| City | State | Zip Code |

## CERTIFICATION AND SIGNATURE

I certify the applicant named above attended the educational institution named above and completed the Respiratory

Therapy Program. He/she was awarded a degree/certificate on _____.

(circle one) (Month/Day/Year)

_____ _____

Signature of Program Director Date

_____

Print or Type Name of Director (Seal) If academic institution has no seal, please indicate.