

Michigan Department of Community Health
Board of Respiratory Care
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

RESPIRATORY THERAPIST RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Respiratory Care. Questions regarding your application can be directed to the Michigan Board of Respiratory Care at (517) 335-0918 three weeks after the date you sent the application. Please allow 6-8 weeks processing time.

GENERAL INSTRUCTIONS FOR RELICENSURE

1. Type or print legibly on all forms and send the original application along with your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN**. Applications received without a fee will be returned to you and will not be considered until the proper fee has been received. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
 2. **Effective October 1, 2008**, all applicants for relicensure of a Michigan health profession license or registration that has been expired for **more** than 3 years are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will **not** be issued until this process is complete.
 3. Verification of licensure from any state where you hold or have ever held a permanent respiratory therapist license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.
 4. If your full license has been lapsed **more** than 3 years, you must either:
 - a. Hold a current,unrestricted license in another state,
- OR-**
- b. Provide documentation that you have passed the certification examination of the National Board of Respiratory Care (NBRC) within the 2 years immediately preceding your application for relicensure.
 5. If your full license has been lapsed **more** than 3 years and you cannot verify either (a) or (b) above, you must become credentialed by the NBRC and have NBRC send verification of your credentialed status to the Michigan Board. NBRC can be contacted at 913-599-4200 or on their website at www.nbrc.org.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Respiratory Care in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Respiratory Care in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
4. ORIGINAL RELICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

CRIMINAL BACKGROUND CHECK FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)

1. Complete the attached Livescan Fingerprint Request Form and schedule a fingerprinting appointment with L-1 Identity Solutions. A fee of \$62.75 is required for the fingerprinting process. The fee may be paid while registering on-line or at the fingerprinting appointment with either a business check or money order. Please note: The Agency ID Number needed for scheduling is 71734k.
2. To schedule a fingerprinting appointment on-line (Michigan locations only):

Register with the approved fingerprinting vendor, L-1 Identity Solutions, at www.L1enrollment.com

Select Michigan as the State for which you are being fingerprinted, then complete the registration process and finalize your appointment at a location that is convenient for you..
3. To schedule a fingerprinting appointment by telephone (Michigan locations only):

Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) and a representative will schedule the fingerprinting appointment and assist you in identifying a convenient location.
4. Please have the following with you upon arriving at your fingerprinting appointment:

The attached completed Livescan Fingerprint Request Form.

A driver's license or other state or federal issued picture identification (government ID, passport, military ID).

A business check or money order for \$62.75 made payable in U.S. Funds to: L-1 Identity Solutions, unless you have made payment on-line.
5. A technician will scan your fingerprints and submit the data electronically to the Michigan State Police.
6. You will receive a signed receipt at the end of your fingerprinting session, which will include a TCN identification number that can be kept as proof of completing the fingerprinting process.
7. If no criminal history information is found, the Bureau of Health Professions will be notified.
8. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
9. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 322-1956.



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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**CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS
(For applicants out of state or out of country)**

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card or on another state's official fingerprint card. The ink fingerprint must be completed on card stock.
2. Submit the card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$62.75 made payable in U.S. Funds to L-1 Identity Solutions to the following address:

L-1 Enrollment Services/LiveScan Processing Unit
1650 Wabash Ave. Ste. D
Springfield, IL 62704

3. Please include a daytime telephone number or e-mail address where you can be reached if there are any questions.
4. L-1 Identity Solutions will submit your fingerprints to the Michigan State Police for analysis.
5. If no criminal history information is found, the Bureau of Health Professions will be notified.
6. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
7. Call L-1 Identity Solutions toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
8. L-1 Identity Solutions is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 322-1956.

LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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Applicant Instructions: Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:	State or Country of Birth:		
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

REQUESTING AGENCY INFORMATION

Agency I.D. Number: 71734k	Agency Name: Department of Community Health, Bureau of Health Professions
Reason Fingerprinted: LHP - Licensed Health Care Professional	Cost: \$62.75

****Disclaimer:** Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY**. **MSP** will charge for dual fingerprinting (transmission), etc.

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APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued.

Type or Print Only

I AM APPLYING FOR THE FOLLOWING: <input type="checkbox"/> Full License Relicensure Fee: \$115.00 71-4401-06 <input type="checkbox"/> Temporary License Relicensure Fee: \$115.00 71-4101-06 Your check or money order drawn on a U.S. financial institution and made payable to the STATE OF MICHIGAN must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.			Board Use Only		
			License Number		
First Name		Middle Name		Last Name	
U.S. Social Security Number		Date of Birth		Daytime Phone Number ()	
Street Address					
City		State		ZIP Code	
All Previous Names and/or Birth Name Used (if applicable)				E-Mail Address	
Has your Michigan respiratory therapist license been lapsed more than three years? <input type="checkbox"/> No <input type="checkbox"/> Yes				Michigan Permanent I.D. Number and Expiration Date	

Check the appropriate answer to each of the following questions. **NOTE: Attach a detailed explanation for any Yes answer you check.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? Yes No

9. Do you hold or have you ever held a respiratory therapist license in any other state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure or registration directly to this board office. (Attach additional sheets if necessary.) Yes No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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Michigan Department of Community Health
Bureau of Health Professions
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VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Audiology	<input type="checkbox"/> Medicine	<input type="checkbox"/> Osteopathy
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Counseling	<input type="checkbox"/> Nursing Home Adm.	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician's Assistants
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Optometry	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Psychology	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Sanitarians
	<input type="checkbox"/> Social Work	<input type="checkbox"/> Veterinary
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board