Adult Critical Care Specialty Examination

The following instructions are provided to help you complete your application when applying for the **Adult Critical Care Specialty Examination.** Read the admission policies for this examination to be sure you qualify. Identify your status from one of the candidate categories listed in bold type below, print off the Specialty Examination application, and follow the instructions provided:

STEP 1: Select the examination for which you are applying and the application fee from Section I: EXAMINATION INFORMATION on the application form.

If you are applying as a reapplicant or are applying to retake the examination to comply with CCP requirements:

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III: ELIGIBILITY STATUS (check box 2 or 4).

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If you are a Registered Respiratory Therapist (RRT) and have 12 months of clinical experience in an adult critical care treatment setting:

A. Complete Sections I, II, III, V, VI, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III C: ADULT CRITICAL CARE SPECIALTY EXAMINATION ELIGIBILITY (check box 1).

D. Note Section V: EMPLOYMENT INFORMATION. Please specify your exact employment dates (month, day, year) which document that you have completed 12 months of clinical experience in adult critical respiratory care following Certification. **Clinical experience must be completed at the time you submit the credentialing examination application.**

E. Note Section VI: VERIFICATION OF CLINICAL EXPERIENCE. Your Medical Director must verify your clinical experience by signing in the space provided in Section VI. If Section VI is not signed by your Medical Director, your application will be considered incomplete. **The NBRC reserves the right to confirm the information you provide by independently contacting your Medical Director.**

If you are applying as a candidate for voluntary recredentialing:

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III: ELIGIBILITY STATUS (check box 3).

Certification Examination for Entry-Level Pulmonary Function Technologists (CPFT)

The following instructions are provided to help you complete your application when applying for the **Certification Examination for Entry-Level Pulmonary Function Technologists (CPFT).** Read the admission policies for this examination to be sure you qualify. Identify your status from one of the candidate categories listed in bold type below, print off the Specialty Examination application, and follow the instructions provided:

STEP 1: Select the examination for which you are applying and the application fee from Section I: EXAMINATION INFORMATION on the application form.

If you are applying as a reapplicant or are applying to retake the examination to comply with CCP requirements:

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III: ELIGIBILITY STATUS (check box 2 or 4).

If you are applying as a graduate of an accredited respiratory therapy education program with a minimum of an associate degree:

A. Complete Sections I, II, III, IV, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III D: CPFT EXAMINATION ELIGIBILITY (check box 1).

D. Note Section IV: EDUCATION INFORMATION. Please specify the exact date (month, day, year) you began and completed an accredited respiratory therapy program. If you graduated from an accredited respiratory therapy education program, print the program's CoARC (previously JRCRTE) number in the space provided. You must obtain the six-digit CoARC number from the accredited respiratory therapy education program from which you graduated.

E. Enclose official transcripts* from an accredited respiratory therapy education program.

If you are a Certified Respiratory Therapist (CRT) or Registered Respiratory Therapist (RRT):

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III D: CPFT EXAMINATION ELIGIBILITY (check box 2 or 3).

If you have completed 62 semester hours of college credit from a college or university accredited by its regional association or its equivalent, including courses in biology, chemistry, and mathematics, and a minimum of six months of clinical experience in pulmonary function technology:

A. Complete Sections I, II, III, IV, V, VI, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III D: CPFT EXAMINATION ELIGIBILITY (check box 4).

D. Note Section IV: EDUCATION INFORMATION. Please indicate colleges or university attended and dates of attendance. List the course numbers and titles which reflect your completion of biology, chemistry, and mathematics. Enclose your official college transcripts* verifying your completion of the required courses.

E. Note Section V: EMPLOYMENT INFORMATION. Please specify your exact employment dates (month, day, year) which document that you have completed six-months of full-time clinical experience in pulmonary function technology. **Clinical experience must be completed at the time you submit the credentialing examination application.**

F. Note Section VI: VERIFICATION OF CLINICAL EXPERIENCE. Your Medical Director must verify your clinical experience by signing in the space provided in Section VI. If Section VI is not signed by your Medical Director, your application will be considered incomplete. **The NBRC reserves the right to confirm the information you provide by independently contacting your Medical Director.**

G. Enclose official transcripts* verifying 62 semester hours of college credit. Your transcripts must also verify completion of biology, chemistry, and mathematics.

If you are a high school graduate (or the equivalent) and have completed two years of clinical experience in the field of pulmonary function technology:

A. Complete Sections I, II, III, V, VI, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III D: CPFT EXAMINATION ELIGIBILITY (check box 5).

D. Note Section V: EMPLOYMENT INFORMATION. Please specify your exact employment dates (month, day, year) which document that you have completed two years of full-time clinical experience in pulmonary function technology. **Clinical experience must be completed at the time you submit the credentialing examination application.**

E. Note Section VI: VERIFICATION OF CLINICAL EXPERIENCE. Your Medical Director must verify your clinical experience by signing in the space provided in Section VI. If Section VI is not signed by your Medical Director, your application will be considered incomplete. **The NBRC reserves the right to confirm the information you provide by independently contacting your Medical Director.**

F. Submit a notarized copy of your high school diploma.

If you are applying as a candidate for voluntary recredentialing:

A. Complete Sections I, II, III, and VII.

B. Note SECTION I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III: ELIGIBILITY STATUS (check box 3).

*NOTE: Most colleges will not release official transcripts to students. If you cannot obtain official transcripts to enclose with your application, instruct your school to send your transcripts to the NBRC. Neither unofficial or student transcripts, nor letters will be accepted as verification of college semester hours completed.

Registry Examination for Advanced Pulmonary Function Technologists (RPFT)

The following instructions are provided to help you complete your application when applying for the **Registry Examination for Advanced Pulmonary Function Technologists (RPFT).** Read the admission policies for this examination to be sure you qualify. Identify your status from one of the candidate categories listed in bold type below, print off the Specialty Examination application, and follow the instructions provided:

STEP 1: Select the examination for which you are applying and the application fee from Section I: EXAMINATION INFORMATION on the application form.

If you are applying as a reapplicant or are applying to retake the examination to comply with CCP requirements:

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III: ELIGIBILITY STATUS (check box 2 or 4).

If you are a Certified Pulmonary Function Technologist (CPFT)*:

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III E: RPFT EXAMINATION ELIGIBILITY (check box 1).

***NOTE:** Individuals who successfully completed the CCPT Examination with a specialty in pulmonary function technology previously offered by the National Society for Cardiopulmonary Technologists (NSCPT) were recognized as CPFTs by the NBRC in July 1984 and are eligible for the RPFT Examination.

If you are applying as a candidate for voluntary recredentialing:

A. Complete Sections I, II, III, and VII.

B. Note Section I: EXAMINATION INFORMATION. Check the box indicating the examination fee enclosed with your application.

C. Indicate your status in Section III: ELIGIBILITY STATUS (check box 3).

CRT & RRT Credentialing Examination Application

(The Specialty examination application is available on the NBRC website.)

I. EXAMINATION INFORMATION

Check the examination for which you are applying:

- ☐ CRT
- ☐ RRT (Date of CRT _____)
  - ☐ RRT Written only ☐ CSE only
  - ☐ Both RRT Written and CSE

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	Recredentialing Fee Active	Recredentialing Fee Inactive
CRT	☐ $190	☐ $150	☐ $75	☐ $150
RRT Written Only	☐ $190	☐ $150	☐ $75	☐ $150
RRT CSE Only	☐ $200	☐ $200	☐ $125	☐ $200
RRT Both	☐ $390	☐ $350	☐ $200	☐ $350

☐ Expired Certification Application Fee – (check if applicable)
A one-time compliance fee of $150 per examination type is required for each examination type of 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.

☐ Discounted Fee (check if applicable)
If you apply for both portions of the RRT within sixty (60) days of earning the CRT credential you qualify for a $50 examination fee discount. Refer to page 8 of the NBRC Candidate Handbook for information about examination fee discounts.

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.

II. 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)

E-mail Address

III. 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;*** the last time I was scheduled for or attempted this examination was:
(MM/DD/YYYY) _____.
List prior names, if applicable.

Last Name First Name

Reapplicants are not required to provide any further eligibility status information.

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

☐ I am applying to retake an examination to comply with CCP requirements:
- ☐ My credential has not yet expired.
- ☐ My credential has already expired. A compliance fee of $150 and new applicant fee applies.

☐ I am applying for the CRT Examination to regain eligibility for the RRT Examination. New applicant fee applies.

A. CRT Examination Eligibility – For *New* Applicants Only
(check only one box)

☐ I have a minimum of an associate degree from an entry-level respiratory therapy education program.

☐ I have a minimum of an associate degree from an advanced-level respiratory therapy education program.

☐ I am enrolled in an accredited respiratory therapy education program in an institution offering a baccalaureate degree and have been awarded a special certificate of completion approved by the CoARC.

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

☐ I am a CRT having earned a minimum of an associate degree from an accredited advanced-level respiratory therapist education program.

☐ I am a CRT having been awarded a special certificate of completion approved by the CoARC from an accredited respiratory therapy education program in an institution offering a baccalaureate degree.

CRT-to-Registry Provision:

☐ I am a CRT with four years of full-time clinical experience* in respiratory care under licensed medical supervision following Certification and prior to applying for the examination and have at least 62 semester hours of college credit from a college or university accredited by its regional association or the equivalent, including courses in anatomy and physiology, chemistry, mathematics, microbiology, and physics.

☐ I am a CRT with an associate degree in respiratory therapy from an accredited entry-level respiratory therapy education program with two years of full-time clinical experience* in respiratory therapy under licensed medical supervision following Certification.

☐ I am a CRT with a baccalaureate degree in an area other than respiratory care and have two years of full-time clinical experience* in respiratory care under licensed medical supervision following Certification and prior to applying for the examination have at least 62 semester hours of college credit from a college or university accredited by its regional association or the equivalent, including courses in anatomy and physiology, chemistry, mathematics, microbiology, and physics.

* Full time experience is defined as a minimum of 21 hours per week per calendar year. Clinical experience must be completed before the candidate applies for the examination.

National Board for Respiratory Care, Inc. • 18000 W. 105th Street • Olathe, KS 66061-7543
913/895-4900 or 888/341-4811 • Fax 913/895-4650 • www.nbrc.org

CRT & RRT Credentialing Examination Application, continued

IV. A. EDUCATION INFORMATION

(New Applicants Only)

Provide the information requested about the accredited respiratory therapy education 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. For RRT "CRT-to-Registry" 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 RRT "CRT-to-Registry" admission route.

	Course No.	Course Title
Anatomy/Physiology		
Chemistry		
Mathematics		
Microbiology		
Physics		

VI. VERIFICATION OF CLINICAL EXPERIENCE

(RRT 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

V. EMPLOYMENT INFORMATION

(RRT New Applicants only)

RRT Applicants: Complete this section ONLY if you are applying under the CRT-to-Registry admission provision. CRTs certified before January 1, 1983 must document three years of full-time clinical experience following Certification; CRTs certified after January 1, 1983 must document four years of full-time clinical experience following Certification.

Provide the required information about your present and previous employment.

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

VII. 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. I also understand that allowing my file for the RRT Examination to become inactivated will result in any previous passing performance on a portion of the RRT Examination being nullified and that I will have to repeat and successfully complete said portion(s) to earn the RRT credential. 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

Specialty Credentialing Examination Application

I. EXAMINATION INFORMATION

Check the examination for which you are applying:

- ☐ Neonatal/Pediatric Specialty (Date of CRT or RRT _____)
- ☐ Sleep Disorders Specialty (Date of CRT or RRT _____)
- ☐ Adult Critical Care Specialty (Date of RRT _____)
- ☐ CPFT
- ☐ RPFT (Date of CPFT _____)

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	Recredentialing Fee Active	Recredentialing Fee Inactive
Neonatal/Pediatric	☐ $250	☐ $220	☐ $75	☐ $220
Sleep Disorders	☐ $300	☐ $250	☐ $75	☐ $250
Adult Critical Care	☐ $300	☐ $250	☐ $75	☐ $250
CPFT	☐ $200	☐ $170	☐ $75	☐ $170
RPFT	☐ $250	☐ $220	☐ $75	☐ $220

☐ Expired Certification Application Fee – (check if applicable)
A one-time compliance fee of $150 per examination type is required for each examination type of 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.

☐ Discounted Fee (check if applicable)
If you apply for an advanced-level examination (RPFT, NPS) within sixty (60) days of earning an entry-level credential (i.e., CRT, CPFT) you qualify for a $50 examination fee discount. Refer to page 8 of the NBRC Candidate Handbook for information about examination fee discounts.

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.

II. 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)

E-mail Address

III. 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;*** the last time I was scheduled for or attempted this examination was:
(MM/DD/YYYY) _____.
List prior names, if applicable.

Last Name First Name

Reapplicants are not required to provide any further eligibility status information.

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

☐ I am applying to retake an examination to comply with CCP requirements:
- ☐ My credential has not yet expired.
- ☐ My credential has already expired. A compliance fee of $150 and new applicant fee applies.

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

☐ I am an RRT.

☐ I am a CRT with 12 months of clinical experience* in neonatal/pediatric respiratory care.

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 program including a sleep add-on track.

☐ I am an RRT with three months of full-time clinical experience* in a sleep diagnostics and treatment setting under medical supervision following Certification (MD, DO or PhD).

☐ I am an CRT with six months of full-time clinical experience* in a sleep diagnostics and treatment setting under medical supervision following Certification (MD, DO or PhD).

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

☐ I am an RRT with at least one year of full-time clinical experience* in a critical care setting under medical supervision following Certification (MD, DO or PhD).

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

☐ I have a minimum of an associate degree from a respiratory therapy educational 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 high school graduate (or the equivalent) and have two years 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 prior to applying for the examination.

E. RPFT Examination Eligibility – For *New* Applicants Only

☐ 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.

* Full time experience is defined as a minimum of 21 hours per week per calendar year. Clinical experience must be completed before the candidate applies for the examination.

Specialty Credentialing Examination Application, continued

IV. A. EDUCATION INFORMATION

(CPFT and Sleep Disorders Specialty New Applicants Only)

Provide the information requested about the accredited sleep add-on track (Sleep Disorders applicants only) or pulmonary function technology (CPFT 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

B. For CPFT 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 CPFT admission route.

	Course No.	Course Title
Biology		
Chemistry		
Mathematics		

VI. VERIFICATION OF CLINICAL EXPERIENCE

(CPFT, Sleep Disorders, Adult Critical Care, and Neonatal/Pediatric 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

V. EMPLOYMENT INFORMATION

(CPFT, Sleep Disorders, Adult Critical Care, and Neonatal/Pediatric New Applicants only)

CPFT 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, or as a high school graduate with at least two years of pulmonary function technology experience.

Neonatal/Pediatric Specialty Applicants: Complete this section ONLY if you are a CRT with 12 months of clinical experience in neonatal/pediatric respiratory care.

Sleep Disorders Specialty Applicants: Complete this section ONLY if you are either a CRT with six months of full-time clinical experience, or an RRT with three months full-time experience in a sleep diagnostics and treatment setting under medical supervision following Certification (MD, DO, or PhD).

Adult Critical Care Applicants: Complete this section.

Provide the required information about your present and previous employment.

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

VII. 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

National Board for Respiratory Care, Inc.
18000 W. 105th Street
Olathe, KS 66061-7543
913/895-4900 or 888/341-4811
www.nbrc.org

Request for Special Examination Accommodations

Please complete this form and the "Documentation of Disability Related Needs" on the reverse side so your accommodation for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside sources without your expressed written consent. **If you have existing documentation of the same or similar accommodation provided for you in another examination situation, you may submit such documentation instead of having the reverse side of the form completed by an appropriate professional.**

Applicant Information

Requested Location: _____

Social Security # _____ – _____ – _____ Requested Examination Date: _____

_____
Last Name First Name Middle Name

_____
Address

_____
City State Zip Code

_____
Daytime Telephone Number

Special Accommodations

I request special accommodations for the examination below.

- ☐ CRT
- ☐ RRT – Written
- ☐ RRT – Clinical Simulation (CSE)
- ☐ CPFT
- ☐ RPFT
- ☐ Neonatal/Pediatric Specialty
- ☐ Sleep Disorders Specialty
- ☐ Adult Critical Care Specialty

Please provide (check all that apply):

- _____ Reader
- _____ Extended testing time (time and a half)
- _____ Reduced distraction environment
- _____ Other special accommodations (please specify)

_____

_____

_____

Comments: _____

_____

_____

Signed:_____ **Date:** _____

Return this form with your examination application to: NBRC, 18000 W. 105th Street, Olathe, KS 66061-7543. If you have questions, call the NBRC at 913/895-4900 or 888/341-4811.

Documentation of Disability-Related Needs

If you have a learning disability, a psychological disability, or other disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested examination accommodation. **If you have existing documentation of the same or similar accommodation provided for you in another examination situation, you may submit such documentation instead of completing the "Professional Documentation" portion of this form.**

Professional Documentation

I have known _____ since ____ / ____ /____ in my capacity
Examination Applicant Date

as a _____.
Professional Title

The applicant discussed with me the nature of the examination administered. It is my opinion that because of this applicant's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Description of Disability: _____

_____

_____

_____

_____

Signed: _____

Title:_____

Date: _____ **License # (if applicable):** _____

Return this form with your examination application to: NBRC, 18000 W. 105th Street, Olathe, KS 66061-7543. If you have questions, call the NBRC at 913/895-4900 or 888/341-4811.

National Board for Respiratory Care, Inc.
18000 W. 105th Street • Olathe, KS 66061-7543
913/895-4900 or 888/341-4811
www.nbrc.org

NBRC Public Relations Questionnaire

The NBRC is interested in your view of the services provided to examination candidates. This questionnaire gives you an opportunity to make suggestions for improving the services and communication with the NBRC.

Please take a few minutes to fill out this questionnaire. Your comments will be reviewed by the NBRC. Through your comments, we can evaluate the effectiveness of our communication and improve our services to you.

Name (optional):_____ Date: _____

I. Telephone and Written Communication

A. Telephone Communication

1. Have you called the NBRC in the past: ☐ year? ☐ Yes ☐ No *(go to Item B)*
   ☐ 6 months? ☐ Yes ☐ No *(go to Item B)*
   ☐ 2 weeks? ☐ Yes ☐ No *(go to Item B)*

   a. What was the purpose of your call? *(check as many as apply)*
   ☐ requested printed information or forms
   How soon after your request did you receive printed information or forms?
   ☐ less than 7 days ☐ 7-14 days ☐ 15-21 days ☐ More than 3 weeks
   ☐ asked routine question about examination policies, application procedures, etc.
   ☐ needed help in resolving a specific problem *(please indicate the nature of the problem):*

   _____

   _____

   _____

   ☐ had a complaint *(please indicate the nature of complaint)*:

   _____

   _____

   _____

   _____

   b. Was your call referred to a person who could help you? _____ ☐ Yes ☐ No

   c. Was the person you talked to courteous? ☐ Yes ☐ No

2. Were you satisfied with the way your call was handled? ☐ Yes ☐ No
   If no, why:_____

   _____

   _____

B. Written Communication

1. Have you written a letter to the NBRC in the past: ☐ year? ☐ Yes ☐ No *(go to Section II)*
   ☐ 6 months? ☐ Yes ☐ No *(go to Section II)*
   ☐ 2 weeks? ☐ Yes ☐ No *(go to Section II)*

   If yes, what was the purpose of your letter? *(check as many as apply)*
   ☐ requested printed information or forms
   How soon after your request did you receive printed information or forms?
   ☐ less than 7 days ☐ 7-14 days ☐ 15-21 days ☐ More than 3 weeks
   ☐ asked a routine question about examination policies, application procedures, etc.
   ☐ needed help in resolving a specific problem *(please indicate nature of problem)*: _____

   _____

   _____

   _____

☐ had a complaint *(please indicate nature of complaint)*: _____

_____

_____

_____

☐ other *(please specify)*: _____

_____

_____

_____

2. Were you satisfied with the way your letter was handled? ☐ Yes ☐ No
   If no, why: _____

_____

_____

II. NBRC Web Site (www.nbrc.org)

1. Have you accessed the NBRC's Home Page on the Web in the past year? ☐ Yes ☐ No
   a. What was the purpose of your inquiry? *(check as many as apply)*
      ☐ general information about examination programs
      ☐ attempt a computerized practice examination
      ☐ request publications or information using the online order form
      ☐ other: _____
2. Have you sent a message to the NBRC by e-mail in the past: ☐ year? ☐ Yes ☐ No
   ☐ 6 months? ☐ Yes ☐ No
   ☐ 2 weeks? ☐ Yes ☐ No
   If yes, did you receive a timely response? ☐ Yes ☐ No Comments: _____

_____

3. Please provide any suggestions or comments about the NBRC's website:

_____

_____

_____

III. Summary Comments

A. Overall, how would you rate the NBRC's communications?
   ☐ excellent ☐ good ☐ fair ☐ poor

B. Any additional comments or suggestions:

_____

_____

_____

_____

_____

Thank you for completing this questionnaire. We appreciate your comments and suggestions. Please return the questionnaire to NBRC, 18000 W. 105th Street, Olathe, KS 66061-7543.

National Board for Respiratory Care, Inc.

Executive Office

18000 W. 105th Street

Olathe, Kansas 66061.7543

Phone: 913.895.4900 or 1.888.341.4811

Fax: 913.895.4650

E-mail: nbrc-info@nbrc.org

Website: www.nbrc.org