



# Respiratory Care Board of California

3750 Rosin Court, Suite 100, Sacramento, CA 95834  
Telephone: (916) 999-2190 Toll Free: (866) 375-0386 Fax: (916) 263-7362  
Website: [www.rcb.ca.gov](http://www.rcb.ca.gov) E-mail: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov)



## IDENTIFICATION UPDATE

PROBATIONER NAME: \_\_\_\_\_ DATE COMPLETED: \_\_\_\_\_

ALIASES [OTHER FIRST AND/OR LAST NAMES EVER USED]: \_\_\_\_\_

RCP LICENSE No.: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CA DRIVER'S LICENSE No.: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME TELEPHONE: ( ) \_\_\_\_\_ PAGER: ( ) \_\_\_\_\_

CELLULAR PHONE: ( ) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

### EMPLOYER INFORMATION:

YOU MUST DISCLOSE **ALL** EMPLOYERS INCLUDING ANY REGISTRIES OR NON-RESPIRATORY CARE FIELD EMPLOYMENT. THIS INCLUDES VOLUNTEER EMPLOYMENT WITH OR WITHOUT COMPENSATION AND INTERNSHIPS WITH OR WITHOUT SCHOOL CREDITS OR ANY OTHER FORM OF COMPENSATION. IF YOU ARE UNSURE WHETHER YOU SHOULD LIST AN EMPLOYER, LIST THE EMPLOYER AND THEN EXPLAIN THE SITUATION.

**EMPLOYER # 1:** \_\_\_\_\_

CHECK ONE: [ ] HOSPITAL [ ] REGISTRY [ ] NON-RESPIRATORY [ ] OTHER \_\_\_\_\_

DEPT. DIRECTOR/ADMINISTRATOR: \_\_\_\_\_ TITLE: \_\_\_\_\_

SUPERVISOR(S): \_\_\_\_\_

EMPLOYMENT ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

MAIN PHONE #: ( ) \_\_\_\_\_ DEPT. PHONE #: ( ) \_\_\_\_\_

WORKING TITLE: [ ] RESPIRATORY CARE PRACTITIONER [ ] OTHER: \_\_\_\_\_

HIRE DATE: \_\_\_\_\_ SHIFT: \_\_\_\_\_

**Employer information (continued)**

**Employer # 2:** \_\_\_\_\_

Check one: [ ] Hospital [ ] Registry [ ] Non-Respiratory [ ] Other \_\_\_\_\_

Dept. Director/Administrator: \_\_\_\_\_ Title: \_\_\_\_\_

Supervisor(s): \_\_\_\_\_

Employment Address: \_\_\_\_\_  
\_\_\_\_\_

Main Phone #: (\_\_\_\_) \_\_\_\_\_ Dept. Phone #: (\_\_\_\_) \_\_\_\_\_

Working Title: [ ] Respiratory Care Practitioner [ ] Other: \_\_\_\_\_

Hire Date: \_\_\_\_\_ Shift: \_\_\_\_\_

**Employer # 3:** \_\_\_\_\_

Check one: [ ] Hospital [ ] Registry [ ] Non-Respiratory [ ] Other \_\_\_\_\_

Dept. Director/Administrator: \_\_\_\_\_ Title: \_\_\_\_\_

Supervisor(s): \_\_\_\_\_

Employment Address: \_\_\_\_\_  
\_\_\_\_\_

Main Phone #: (\_\_\_\_) \_\_\_\_\_ Dept. Phone #: (\_\_\_\_) \_\_\_\_\_

Working Title: [ ] Respiratory Care Practitioner [ ] Other: \_\_\_\_\_

Hire Date: \_\_\_\_\_ Shift: \_\_\_\_\_

All employers must be listed. If you have additional employers, please check here  [ ] and attach an additional sheet of paper with the same information requested for each employer.

---

---

---

**MUST BE COMPLETED**

I hereby submit this Identification Update as required by the Respiratory Care Board and declare under penalty of perjury of the laws of the State of California that all information reported is true and correct in every respect. I understand that any misstatements or omissions of material fact may be cause for the revocation of probation.

\_\_\_\_\_  
Signature 

\_\_\_\_\_  
Date