RESPIRATORY CARE PRACTITIONER
LICENSURE VERIFICATION FORM

(Read Instructions Prior to Completion)

RCP#	Last Name	First Name	License/Work Permit	Renewal Date	Expiration Date	Current & Valid	Delinquent	Disciplinary Action	No Record Found	CONTACT BOARD

Requestor's Information

(This information MUST be completed)

_____ Requestor's Name

_____ Title

_____ Hospital/Employer

( ) _____ Telephone Number

( ) _____ Fax Number

_____ Email address (i.e., *name@company.com)*

RCB USE ONLY

Date Rec'd _____ **Date Comp'd** _____ **Faxed by**_____