Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

RESPIRATORY CARE PRACTITIONER CERTIFICATE OF PROFESSIONAL EDUCATION

APPLICANT: Complete this section and submit to certifying school for completion. Form must be returned directly from the school to the Department.

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Address (number/street)	(city)	(state)	(zip code)

Date of Birth	**Social Security Number** (voluntary-for use by school to locate your records)	**Date of Graduation** (Anticipated dates of graduation will not be accepted.)
__/__/____	___-__-____	__/__/____

Application Number	**PAR-**	

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

	__/__/____
Applicant Signature (Provide a digital signature or print and sign form.)	**Date**

SCHOOL: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of credential application.)

Name of School				
Location of School (city, state)	**City**		**State**	
Type of Degree Awarded				
Major				
Date Diploma Granted	__/__/____	(Anticipated dates of graduation will not be accepted.)		

Accreditation: Was this program or course of instruction in respiratory care approved by the Joint Review Committee on Education in Respiratory Care (JRCRC) or the Commission on Accreditation for Respiratory Care (CoArc) or a JRCRC or CoArc successor organization at the time of the applicant's graduation?	☐ Yes ☐ No

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ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Dean or Department Head
Provide a digital signature or print and sign form.)

Date __/__/____

Printed Name

Phone ___-___-____ Ext_____

Title