



Alabama State Board of Respiratory Therapy

P. O. Box 241386, Montgomery, AL 36124-1386

Phone: 334-396-2332 Fax: 334-396-2384

Web Site: www.asbrt.alabama.gov

VERIFICATION OF RESPIRATORY THERAPY LICENSE

I, _____ am applying for a respiratory therapy license in the state of Alabama. I hereby authorize and request the Board of _____, its staff, or representative having control of any documents, records, and other information pertaining to me, to provide the Alabama State Board of Respiratory Therapy any and all information requested on this form, and any pertinent information regarding final actions taken against my license to practice Respiratory Therapy. Further, I request that this completed form be sent directly to the **Alabama State Board of Respiratory Therapy, PO Box 241386, Montgomery, AL 36124-1386**. I understand completed forms returned to me will not be accepted for verification purposes.

NAME OF APPLICANT (please print): Last: _____ First: _____ Middle: _____

Other names used in obtaining licensure _____

Date of Birth ____/____/____ Social Security Number: _____ - _____ - _____

License Number _____ Issue Date: ____/____/____

(Signature of Applicant)

Current Address: _____

For verification of LICENSURE
Please provide exact dates.

The following section must be completed by an official of the licensure board and returned directly to the Alabama State Board of Respiratory Therapy. **Verifications returned to the applicant will not be accepted.** Any substitutions must contain all required information or it will not be accepted for verification purposes. State Seal must be affixed to be accepted.

State of _____

Full Name of Licensee _____, License number _____

Issue Date ____/____/____ Expiration Date ____/____/____

Active ____ Inactive ____ Lapsed ____ Other (explain on back) ____

- Has the applicant ever been warned, censured, or disciplined in any manner by a licensing or disciplinary authority in your state? Yes No
If yes, please provide date(s) ____/____/____, ____/____/____
- Has his/her application for initial licensure or reinstatement ever been denied or withdrawn? Yes No
If yes, please provide dates (s) ____/____/____, ____/____/____
- Is this respiratory Therapist currently under investigation by your state board? Yes No

Comments, if any: _____

Signature Title Date

Phone BOARD SEAL: