State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215
(614) 466-3934 *med.ohio.gov*

VERIFICATION OF EDUCATION

STUDENT INSTRUCTIONS:

- Complete the page 1 of this form **(Print or Type)**.
- Provide this form to your respiratory care program director for completion.
- **E-mail completed form to the State Medical Board at license@med.ohio.gov**
- Once your limited permit is issued, you will receive a copy of this form. A copy **must be filed with each employer**.

SECTION A: PERSONAL INFORMATION

First Name	*Middle Name*	*Last Name*		*Email*	
Address		*City*	*State*	*Zip Code*	*County*

SECTION B: EDUCATIONAL INSTITUTION INFORMATION

School Name				
Address	*City*	*State*	*Zip Code*	*County*

I hereby authorize the above-named school to release to the State Medical Board of Ohio the information requested on this form. I further authorize the State Medical Board of Ohio to release information contained on this form, upon my request, to any place of employment which respiratory care is provided and to request any additional information needed to process this form.

* _____
Signature of Student

* _____
Date

DO NOT WRITE BELOW THIS LINE - FOR BOARD USE ONLY

LIMITED PERMIT NUMBER	ISSUE DATE

Limited permits expire annually on June 30th unless renewed. A person issued a limited permit may practice respiratory care under the limited permit for not more than three years after the date the limited permit is issued, except that the limited permit shall cease to be valid one year following the date of receipt of a certificate of completion from a board-approved respiratory care education program, or immediately if the holder discontinues participation in the educational program. The status and expiration date of a limited permit may be verified at https://elicense.ohio.gov/OH_HomePage.

SECTION C: STUDENT INFORMATION

First Name	*Middle Name*	*Last Name*

PROGRAM DIRECTOR INSTRUCTIONS:

- Complete Sections D and E of this form **(Type or Print)**.
- Return completed form to the student named above.

SECTION D: PROGRAM INFORMATION AND ENROLLMENT STATUS

Is the student enrolled in and in good standing in an ORCB-approved respiratory care educational program?	□ Yes	□ No
What is the type of respiratory care educational program?	□ Associate	□ Bachelor
What was the initial date of the student's enrollment in the program?	*Month*	*Year*
What is the anticipated date of program / degree completion?	*Month*	*Year*

SECTION E: BASIC SKILLS CHECK LIST: Please mark appropriate box for each skill and date

YES	NO	SKILL/PROCEDURE - BASIC	DATE DOCUMENTED
		1. Oxygen Administration and applying equipment for such purposes	
		2. Administering other medical gases and applying equipment for such purposes	
		3. Administering bland aerosol and humidification devices and applying equipment for such purposes	
		4. Administering, monitoring and recording the results of aerosolized medication procedures	
		5. Performing hyperinflation therapy and applying equipment for such procedures	
		6. Performing airway clearance therapy, postural drainage, percussion/vibration (manual or mechanical), coughing techniques, and applying equipment for such purposes	
		7. Basic airway management: a. Manual ventilation b. Oral and nasal airway placement	
YES	**NO**	**SKILL/PROCEDURE - INVASIVE**	**DATE DOCUMENTED**
		8. Performing airway suctioning: a. Endotracheal b. Naso-tracheal	
		9. Obtaining arterial or other blood samples for testing: a. Percutaneous b. Arterial line	
		10. Analyzing, testing, measuring, and monitoring blood and gas samples	
YES	**NO**	**SKILL/PROCEDURE - ADVANCED**	**DATE DOCUMENTED**
		11. Set up and applying mechanical ventilation	
		12. Monitoring, evaluating, and recording the results of mechanical ventilation	
		13. Performing cardiopulmonary resuscitation	
		14. Performing endotracheal intubation	

YES	NO	SKILL/PROCEDURE - ADVANCED CONT'D	DATE DOCUMENTED
		15. Performing endotracheal extubation	
		16. Tracheostomy care	
		17. Set up and applying Non-invasive Positive Pressure Ventilation (NPPV)	
		18. Set up and applying fixed CPAP (nocturnal)	
YES	**NO**	**SKILL/PROCEDURE - PULMONARY FUNCTIONS**	**DATE DOCUMENTED**
		19. Obtaining flows, pressures, and volumes for pulmonary function testing a. Bedside b. Laboratory	
YES	**NO**	**SKILL/PROCEDURE - EDUCATION, REHABILITATION AND HOME CARE**	**DATE DOCUMENTED**
		20. Providing in-patient education and monitoring response	
		21. Providing pulmonary rehabilitation	

I certify that the above-named individual (student) is enrolled in and is in good standing in the above named respiratory educational program. I furthermore certify that the student has successfully completed all skill and procedure areas marked "YES".

*

Signature of Program Director Date

*

Print Name

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RESPIRATORY CARE STUDENT AUTHORIZATION FOR RELEASE OF ACADEMIC, TECHNICAL SKILL AND PERFORMANCE STATUS

INSTRUCTIONS:

- Please complete and sign this form
- Provide original form to the Educational Program Director
- Provide a copy of this form to the Board, attach to completed Verification of Education Form

Student Name: _____
(PRINT) (Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Respiratory Care Educational Program: _____

I hereby consent to the release of my educational records and/or information pertaining to my academic, technical skill, or performance status in the respiratory care educational program listed in part A of this form to the State Medical Board of Ohio for the purpose of documenting my compliance with Section 4761.05 (B)(1)(a) of the Ohio Revised Code. I acknowledge that this information may be used to determine my eligibility for a limited permit to practice respiratory care as well as my future eligibility for a respiratory care license and/or continued retention of either should any be issued by the State Medical Board of Ohio. Information will be released by the designated director of the respiratory care program.

Date: _____ Signature: _____