TEXAS BOARD OF RESPIRATORY CARE

RESPIRATORY CARE PRACTITIONER
REQUEST FOR VOLUNTARY CHARITY CARE

Respiratory Care Practitioner's Name _____
(Please print)

Respiratory Care Practitioner's Certificate Number _____
(Please print)

BEFORE ME, the undersigned notary public, on this day personally appeared _____, who after being by me duly sworn, upon his oath deposed and said:

1. I hereby request that my Texas Respiratory Care Practitioner certificate, _____, be placed on official Voluntary Charity Care Status.
2. I certify that my practice of respiratory care is without compensation or expectation of compensation.
3. I acknowledge that in order to qualify for this status I must obtain and report continuing education as required under the Respiratory Care Practitioners Act, TEX. OCC. CODE ANN. 604.154 and Texas Administrative Code 187.16
4. I understand that in order to qualify for this status I must file a completed registration application with the Texas Board of Respiratory Care (TBRC) biennially as required under the Texas Administrative Code 187.15.
5. I understand that I must request and execute the Voluntary Charity Care affidavit with each registration.
6. I understand that as a retired respiratory care practitioner under the TBRC whose only practice of respiratory care is voluntary charity care as described above, I shall be exempted from the biennial registration fee.
7. I understand that should I return to an active status, I will be required to register and pay the registration fee in force at that time.
8. I understand that I remain subject to disciplinary action under the Respiratory Care Practitioners Act, TEX. OCC. CODE ANN. 604.201, based on dishonest or unethical conduct if I engage in the compensated practice of respiratory care.
9. I understand that my attempts to obtain an exemption from the registration under this section by submitting false or misleading statements to the TBRC shall render me subject to disciplinary action pursuant to the Respiratory Care Practitioners Act, TEX. OCC. CODE ANN. 604.201(b)(1), in addition to any civil or criminal actions provided for by state or federal law.

_____ _____
Respiratory Care Practitioner's Signature Date

SUBSCRIBED & SWORN to me by _____, before me on this the _____day of _____, 20_____, to certify which, witness my hand and seal of office.

_____
Notary Public Signature

Notary's Printed Name: _____
NOTARY SEAL

State of _____

My Commission Expires: _____

Location Address:
1801 Congress Ave, Suite 9-200
Austin, Texas 78701

Mailing Address:
P.O. Box 2029
Austin, Texas 78768-2029
www.tmb.state.tx.us

Contact Information:
Phone 512.305.7030
Registration Fax 888. 512.2581
registrations@tmb.state.tx.us