RCP 1
Verification of CRT/RRT Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
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Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
_____ Y _____ N
Date verified _____

VERIFICATION OF PROFESSIONAL EDUCATION FOR RESPIRATORY CARE PRACTITIONER LICENSURE

Part 1

APPLICANT: Complete Part 1 and send to the institution where you completed your Respiratory Therapy program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: _____/_____/_____ Social Security Number: _____- _____ - _____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2

REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please email this form to: *mdh.mbpcredentials@maryland.gov*.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

☐ Associate's Degree ☐ Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐ Other:_____
(specify)

in _____. The program was accredited by: _____
Educational Program CoARC, CAAHEP, CAHEA, etc.

_____ _____
Printed Name of Authorized Official Name of Institution

_____ _____ _____
Title of Authorized Official Telephone Number Fax Number

_____ _____
Signature of Authorized Official Date

SEAL OF THE INSTITUTION