Respiratory Care
Verification of Professional Education for Licensure

Instruction to Applicant:
Upon completion of the demographic information and waiver below, this form should be signed, notarized, and sent to the Institution where you obtained your degree in Respiratory Care.

Date	
Name (Last, First, Middle, Initial)	*Maiden Name or Given Surname*
Address (Street, City, State and Zip Code)	*Phone Number* ( ) *Home* ( ) *Work* ( )
Social Security Number	*Date of Graduation*

Waiver for the Release of Information:
I am applying for licensure as a Respiratory Care Practitioner in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure – Respiratory Care, should this information be requested at any time.

_____ _____
Date *Signed*

Subscribed and sworn to before me this day of _____ 20 __.

My commission expires _____ 20 ___.

_____
Notary Signed

Seal

Instructions to Educational Institution:
Upon completion of this form please send to: Mississippi State Department of Health
Professional Licensure - Respiratory Care
Post Office Box 1700
Jackson, Mississippi 39215-1700

Name of Institution	*Location of Institution (City & State)*
Dates of Attendance (Month/Year) From: To:	*Total Number of Academic Years*
Dates Degree Conferred, or, Expected Date	*Degree Conferred, or, to be Conferred*
Program Name & Curriculum Description	

Seal of the Institution

_____
Name

_____
Title

_____
Telephone Number