

VERIFICATION OF EDUCATION FORM



OHIO RESPIRATORY CARE BOARD
77 S. High Street, 16th Floor
Columbus, Ohio 43215-6108
614.752.9218
www.state.oh.us/rsp

STUDENT INSTRUCTIONS:

- Complete the "Front Side" of this form (**Print or Type**).
- Provide this form to your respiratory care program director for completion.
- Attach completed form with your **APPLICATION FOR INITIAL LIMITED PERMIT** form or for future updates.
- 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

<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>	<i>Social Security No. (required*)</i>		
<i>Address</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>County</i>

- Provision of your Social Security Number is mandated for child support enforcement purposes, pursuant to Ohio Revised Code 2301.37(E) and 42 U.S.C. § 1320a-7e(b), 5 U.S.C. §552a, and 45 C.F. R. pt. 61 for potential disclosure to the Federal Department of Health and Human Services' Healthcare Integrity and Protection Data Bank (HIPDB).

SECTION B: EDUCATIONAL INSTITUTION INFORMATION

<i>School Name</i>					
<i>Address</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>County</i>

I hereby authorize the above named school to release to the Ohio Respiratory Care Board the information requested on this form. I further authorize the Ohio Respiratory Care Board 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	EXPIRATION DATE

THE ABOVE EXPIRATION DATE IS **VALID** UNLESS ONE OF THE FOLLOWING CONDITIONS OCCURS FIRST:

- Three (3) years after the initial issue date of the Limited Permit; **or**
- Until the Limited Permit Holder discontinues participation in the educational program; **or**
- One (1) year following the date of receipt of a degree or certificate of completion from a board approved respiratory care educational program

THIS FORM IS NOT VALID UNLESS STAMPED WITH THE BOARD SEAL



Ohio Respiratory Care Board

77 South High Street, 16th Floor * Columbus, Ohio 43215-6108 * (614)752-9218 * Fax (614)728-8691

Respiratory Care Student Authorization for Release of Academic, Technical Skill and Performance Status

INSTRUCTIONS:

- 1) Please complete and sign this form
- 2) Provide original form to the Educational Program Director
- 3) 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 Ohio Respiratory Care Board 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 Ohio Respiratory Care Board. Information will be released by the designated director of the respiratory care program.

Date: _____ Signature: _____