MONTANA BOARD OF RESPIRATORY CARE PRACTITIONERS
301 SOUTH PARK, 4th FLOOR
PO BOX 200513
HELENA MONTANA 59620-0513
Phone: (406) 841-2300 Fax: (406) 841-2305
Email: dlibsdrcp@mt.gov
Website: www.respcare.mt.gov

REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE
(THIS IS NOT AN ENDORSEMENT CERTIFICATION)

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold, or ever have held a license.

COMPLETE THE FORM AND MAIL IT TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERFICATION BE SENT TO THE MONTANA BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

LICENSEE INFORMATION

To Whom It May Concern:
I am applying for a license to practice as a Respiratory Care Practitioner in the State of Montana, and the Board of Respiratory Care Practitioners requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

Montana Board of Respiratory Care Practitioners
PO Box 200513
Helena, MT 59620-0513.

Your prompt response is appreciated.

Name (Please Print) ______________________ Signature ______________________

Address: ____

Street or PO Box # City State Zip

My License Number from your State is: ______________ License Type: ______________