

SECTION II: INSTRUCTIONS TO THE SUPERVISOR

- By completing the information below, the supervisor is certifying that the permittee will be employed under the supervision of a currently registered, New York State licensed respiratory therapist or otherwise legally authorized physician and that the supervisor agrees to abide by the following terms and conditions stipulated below and on the permit.
 - The applicant may not practice respiratory therapy until the limited permit is issued.
 - A limited permit shall expire one year from the date of issuance or upon notice to the applicant by the Department that the application for licensure has been denied, or ten days after notification to the applicant of failure on the professional licensing examination, whichever occurs first. (However, if the permittee is awaiting the results of the licensing examination and the limited permit expires, the permit will remain valid until 10 days after notification of the exam results.)

CERTIFICATION OF SUPERVISION - (To Be Completed By Supervisor)

- Applicant's name: _____
- To be employed as respiratory therapist respiratory therapy technician
- Employer:
Name: _____
(Enter full name -- no initials)
Street: _____
City: _____ State: _____ Zip code: _____ - _____
Telephone: _____ Fax: _____ E-mail: _____
- If practice site is different from employer address (item 3), provide that address also:
Name: _____
Street: _____
City: _____ State: _____ Zip code: _____ - _____
Telephone: _____ Fax: _____ E-mail: _____

5. ATTESTATION

I certify that the applicant named in Section I will be employed under the supervision of a currently registered New York State licensed respiratory therapist or otherwise legally authorized physician and that the supervisor agrees to abide by the conditions stipulated above and on the permit.

I declare and affirm that the information provided in the foregoing certification is true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for disciplinary action against my license.

Direct supervision will be provided by: (please check one) respiratory therapist physician

Name of supervisor: _____ (please print or type) N.Y. License No. _____

Signature: _____ Date: ____/____/____
mo. day yr.

If applicant requests more than one employer or supervisor, a separate Form 5 must be completed for each. (Only one limited permit fee is required.)

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.