

Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

PRACTICE OF RESPIRATORY CARE

Please clearly print

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Enter below the percentages of time you have engaged in practice, taught or directed respiratory care in one or more of the categories listed below during the last three years.

NOTE: NUMBERS 1 – 7 MUST EQUAL 100%

Categories and percentages of practice of respiratory care:	Percentage
1. Aerosolize Medication	_____
2. Oxygen Therapy	_____
3. Cardio-Pulmonary Diagnostics (e.g. ABG, PFT, ECG)	_____
4. Non-invasive Cardio-Pulmonary monitoring (e.g. Apnea, Oximetry, Capnography)	_____
5. Bronchial Hygiene Therapy (e.g. CPT, IPPB, Incentive Spirometry)	_____
6. Cardiology, Special Procedures (e.g. Cath Lab, Stress Testing)	_____
7. Ventilator Care/Airway Management	_____
TOTAL	100%

Name, address, and telephone number of individual who may be contacted to verify the above:

Name: _____ Date: _____
(Please Print)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Applicant's Signature