



MISSISSIPPI STATE DEPARTMENT OF HEALTH

RENEWAL APPLICATION – 2021-2023
CORRECT AND UPDATE ALL
INFORMATION

PERSONAL INFORMATION:

Name: License #: DOB:

Address: County: Phone:

Email address:

EMPLOYER INFORMATION:

Name:

Address: County: Phone:

- 1. Have you been convicted of any violations of law or have any pending charges... YES NO
2. Have any criminal charges or any civil lawsuits been filed against you... YES NO
3. Has any license or permit or registration or professional credential been encumbered... YES NO
4. Do you hold any of the following credentials? Certified Respiratory Therapist (CRT) Registered Respiratory Therapist (RRT)

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

(Applicant's Signature) (Date)

- HAVE YOU 1. REVIEWED THE ABOVE INFORMATION 2. MADE ALL CORRECTIONS AND ANSWER ALL QUESTIONS 3. SIGNED AND DATED THE RENEWAL APPLICATION 4. ENCLOSED THE RENEWAL FEE OF \$100.00 (AND \$200.00 REINSTATEMENT FEE IF POSTMARKED AFTER OCTOBER 31, 2021) 5. ENCLOSED PROOF OF CONTINUING EDUCATION REQUIREMENTS

MAIL TO: MISSISSIPPI STATE DEPARTMENT OF HEALTH PROFESSIONAL LICENSURE – RESPIRATORY CARE P.O. BOX 1700 JACKSON, MS 39215-1700