

## Respiratory Care Verification of Professional Education for Licensure

## **Instructions to Applicant:**

Date

Upon completion of the demographic information and waiver below, this form should be signed, notarized, and sent to the Institution where you obtained your degree in Respiratory Care.

Name (Last, First, Middle, Initial)	Maiden Name or Given Surname
Address (Street, City, State and Zip Code)	Phone Number Home Work
Social Security Number	Date of Graduation
verification of my degree conferred and further authori otherwise to the Mississippi State Department of Health requested at any time.	Care Practitioner in the State of Mississippi. I hereby authorize the ze the release of any transcript or other information, favorable or h, Professional Licensure – Respiratory Care, should this information be
Date Signed	
Profess Post O	sippi State Department of Health sional Licensure - Respiratory Care ffice Box 1700 n, Mississippi 39215-1700
Name of Institution	Location of Institution (City & State)
Dates of Attendance (Month/Year)	Total Number of Academic Years
From: To:  Dates Degree Conferred, or, Expected Date	Degree Conferred, or, to be Conferred
Program Name & Curriculum Description	
Seal of the Institution	Name
	Title  Telephone Number

Mississippi State Department of Health

Form 1310 Initial: 07/12/2022