



**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Health Professional Licensing Administration**  
**899 North Capitol Street, NE, First Floor**  
**Washington, DC 20002**

**RESPIRATORY CARE APPLICANTS:**

**This form must be returned in a sealed envelope and hand delivered to the office of Health Professional Licensing Administration by the Respiratory Therapist applicant. **\*\*Note: You must have a respiratory care application on file.****

**SUPERVISED PRACTICE FORM TO BE COMPLETED BY RESPIRATORY CARE SUPERVISOR**

**TO THE SUPERVISOR:**

This form must be completed if you are supervising an applicant for licensure as a respiratory care therapist. In accordance with 17 DCMR § 7608.7 (Respiratory Care), a supervisor shall be fully responsible for the practice by an applicant during the period of supervision and shall be subject to disciplinary action by the Board for any violation of the Act by the applicant. Pursuant to 17 DCMR § 7608.6 a student or applicant shall wear an identifying name tag or badge indicating student or applicant status.

**The respiratory care applicant may work under supervised practice for ninety (90) days from the date of signature by the supervisor. This supervised practice form shall be issued only one time.**

**Supervisor's Name and License Number (Please Print):**

\_\_\_\_\_  
 LAST NAME,                      FIRST NAME                      MI    LICENSE NUMBER

**Applicant's Name (Please Print):**

\_\_\_\_\_  
 LAST NAME,                      FIRST NAME                      MI

**Location of Supervision (Facility Name):** \_\_\_\_\_

**Brief description of applicant's duties and responsibilities:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SUPERVISOR SIGNATURE	PHONE NUMBER	DATE

**FOR OFFICE USE ONLY**

Date supervision form Submitted: \_\_\_\_\_

Date supervision will end: \_\_\_\_\_

Date of Board review: \_\_\_\_\_

Board Action: \_\_\_\_\_

**DC SEAL**

**HPLA Staff Signature:** \_\_\_\_\_