TELEMEDICINE PROVIDER'S EMPLOYER OR CONTRACTOR CERTIFICATION

State Form 56085 (R5 / 1-19)

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 232-2960
www.pla.IN.gov

INSTRUCTIONS: This Telemedicine Provider's Employer or Contractor Certification ("Certification") is required by Indiana Code §25-1-9.5.

This Certification must be completed and filed with the Indiana Professional Licensing Agency before the employee provider or contract provider may establish a provider-patient relationship or issue a prescription under IC §25-1-9.5-8 for an individual located in Indiana. Note however, that a provider that practices predominantly in Indiana is not required to file this certification.

EMPLOYER OR CONTRACTOR INFORMATION

Name of entity employing or contracting with provider	Does this entity employ or contract with providers? ☐ Yes ☐ No
Name of provider employee or provider contractor	Indiana license number

Is the provider:

- A physician licensed under IC 25-22.5 ☐ Yes ☐ No
- A physician assistant licensed under IC 25-27.5 ☐ Yes ☐ No
- An advanced practice registered nurse licensed and granted authority to prescribe drugs under IC 25-23 ☐ Yes ☐ No
- An optometrist licensed under IC 25-24 ☐ Yes ☐ No
- A podiatrist licensed under IC 25-29 ☐ Yes ☐ No

Address of provider's distant site *(number and street, city, state, and ZIP code)*

Employee identification number of entity	Telephone number of entity ( )	E-mail address of entity

AUTHORIZED REPRESENTATIVE INFORMATION

Name of entity's duly authorized representative with authority to execute this Certification	Title of representative

Address *(number and street, city, state, and ZIP code)*

Telephone number of representative ( )	E-mail address of representative

CERTIFICATION

Employer or contractor agrees to be subject to the jurisdiction of the courts of law of Indiana and Indiana substantive and procedural laws concerning any claim asserted against the provider arising from the provision of health care services under IC §25-1-9.5 to an individual who is located in Indiana at the time the health care services were provided.

The filing of this Certification constitutes a voluntary waiver by the employer or contractor of any respective right to avail themselves of the jurisdiction or laws other than those specified in IC 25-1-9.5-9(b) concerning the claim.

I swear or affirm under the penalties of perjury that the foregoing representations are true.

Signature	Date signed *(month, day, year)*

Printed name