Reset Form

APPLICATION FOR A NON EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) TRAINING PERMIT

State Form 56057 (R2 / 1-21)

MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 4-2-2.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY		
Permit fee	Date fee paid *(month, day, year)*	Receipt number
Permit number	Permit issuance date *(month, day, year)*	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)	Credentials (*check one*) ☐ MD ☐ DO	National Practitioner Identifier number
Social Security number *	Date of birth (*month, day, year*)	Gender ** ☐ Male ☐ Female
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address *(required)*	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

A foreign medical school must meet LCME standards at the time of graduation.

Name of school	Location	Date of graduation *(month, day, year)*

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (*Include ALL internships, residencies and / or fellowships.*)

NAME OF SCHOOL	LOCATION	FROM *(month, year)*	TO *(month, year)*	ACGME / AOA / RC ACCREDITED?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION.

STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1.	Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
2.	Have you ever been denied a license, certificate, registration or permit to practice medicine or any regulated health occupation in any state (*including Indiana*) or country, or surrendered your license?	☐ Yes ☐ No
3.	Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	☐ Yes ☐ No
4.	Have you ever been the subject of an investigation by a regulatory agency concerning your license?	☐ Yes ☐ No
5.	*Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*	
	(1) have you ever been arrested;	☐ Yes ☐ No
	(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☐ Yes ☐ No
	(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☐ Yes ☐ No
	(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☐ Yes ☐ No
	(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ Yes ☐ No
6.	Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7.	Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8.	Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No
9.	Have you surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes ☐ No
10.	Have you ever been excluded from being a Medicare or Medicaid provider?	☐ Yes ☐ No
11.	Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐ Yes ☐ No
12.	Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?	☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)

INSTITUTION CERTIFICATION FOR A TEMPORARY MEDICAL FELLOWSHIP PERMIT

(To be completed by the Hospital / Institution Chairman / Department Head.)

This is to certify that _____ is

enrolled in a postgraduate training program _____ in

the Department of _____

located at *(address)* _____

and will be obtaining training in Indiana at *(address)* _____.

This appointment is for the month and year beginning _____ and ending _____.

Areas of medical practice training		
Name of Hospital Chairman / Department Head	Title	
Signature	Date of signature *(month, day, year)*	Telephone number ( )

SUPERVISING PHYSICIAN ATTESTATION

(To be completed by physician monitoring work of permit holder.)

This is to attest that I, *(name)*_____, *(Indiana licenses number)* _____,

will monitor the work of *(permit holder name)* _____ during the course of

their training in Indiana under this permit.

Signature	Date of signature *(month, day, year)*	Telephone number ( )