Reset Form

APPLICATION FOR INCLUSION ON HEALTHCARE VOLUNTEER REGISTRY BY AN INDIVIDUAL

State Form 56150 (R / 2-17)

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

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

FOR OFFICE USE ONLY	
Date received *(month, day, year)*	Date approved *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

GENERAL INFORMATION

Name of applicant

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

Telephone number	E-mail address	Social Security number*	License number
( )			

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Type of License *(Please check one.)*

- ☐ A Physician under IC 25-22.5
- ☐ A Physician Assistant under IC 25-27.5
- ☐ A Dentist under IC 25-14
- ☐ A Nurse under IC 25.23
- ☐ An Advanced Practice Nurse (as defined in IC 25-23-1-1(b)) who is licensed under IC 25-23
- ☐ An Optometrist under IC 25-24
- ☐ A Podiatrist under IC 25-29