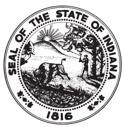

APPLICATION FOR ADMINISTRATOR IN TRAINING FACILITY

State Form 56205 (2-17)

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-3022
E-mail: pla10@pla.IN.gov

INSTRUCTIONS: Please print or type legibly.

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

NOTICE

In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or you application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become public record.

FOR OFFICE USE ONLY			
Date reviewed (*month, day, year*)	Decision	Sponsor identification number	Initials
Preceptor number		Date issued (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

TRAINING FACILITY INFORMATION		
Name of training facility		Type of facility
Address (*number and street, city, state, and ZIP code*)		
Daytime telephone number ( )	E-mail address	Web address

AUTHORIZED INDIVIDUAL INFORMATION		
Printed name of authorized individual	Title	Social Security number*
Signature of authorized individual		Date signed (*month, day, year*)
Telephone number *(Daytime)* ( )	Date of birth (*month, day, year*)	Place of birth *(city, state or foreign country)*

Our organization agrees to periodic state monitoring of our programs at the discretion of the Indiana State Board of Health Facility Administrators ☐ Agree ☐ Do not agree

ADMINISTRATOR-IN-TRAINING INFORMATION
Name of A.I.T. (*last, first, middle, maiden*)
Address of A.I.T. (*number and street, city, state, and ZIP code*)

PRECEPTOR APPLICANT INFORMATION			
Name *(last, first, middle, maiden)*			Social Security number*
Residential address *(number and street or rural route, city, state, and ZIP code)*			
E-mail address *(required)*	RCA / HFA license number	Original issuance date (*month, day, year*)	Expiration date (*month, day, year*)

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 or Indiana State Board of Health Facility Administrators, any files, documents, records or other information pertaining to the undersigned requested by the Agency or the Board or any of their authorized representatives in connection with processing this application for approval of an organization to provide Administrator in Training Courses.

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

I further authorize the Professional Licensing Agency, or the Indiana State Board of Health Facility Administrators 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 and the Board 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.

PRECEPTOR APPLICANT INFORMATION

I hereby swear of affirm that I have read the above statements and agree to same.

Signature of authorized individual	Date signed (*month, day, year*)
Printed name of authorized individual	Title

(*Continued on the reverse side.*)

FACILITY AIT OUTLINE

Please submit syllabus and copies of course load.

Have you ever been qualified as a Preceptor in another state?

☐ Yes ☐ No

If yes, list the state, date of issuance and expiration date *(month, day, year)*.

If your answer is **"yes"** to any of the following, explain fully in a sworn affidavit, including all related details. Include the violation, location, date and disposition. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to the application.

Question	Yes	No
1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	☐ Yes	☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a health facility administrator or any regulated health occupation in **any** state or country?	☐ 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. *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; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ Yes	☐ No
5. 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
6. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as any health care professional?	☐ Yes	☐ No

VERIFICATION

I hereby swear or affirm under the penalties of perjury, that the above statements made in this application including all attachments are true, complete and correct.

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