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APPLICATION FOR CHANGE OR ADDITION OF COLLABORATING PHYSICIAN FOR CERTIFIED DIRECT ENTRY MIDWIFE

State Form 56576 (9-18)

MIDWIFERY COMMITTEE
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. *Completed application should be mailed to the address listed in the upper right hand corner of this form.*
2. *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.

FOR OFFICE USE ONLY

Date received (*month, day, year*)	Date approved (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

TO BE COMPLETED BY THE CERTIFIED DIRECT ENTRY MIDWIFE (*Please print clearly in ink.*)

Name (*last, first, middle*)			License number
Address (*number and street or rural route, city, state, and ZIP code*)			
Social Security number *	Date of birth (*month, day, year*)	E-mail address	Telephone number (*daytime*) ( )
Are you applying for a change of collaborating physician? ☐ Yes ☐ No		Are you adding a collaborating physician? ☐ Yes ☐ No	
Name of collaborating physician prior to completion of this application		Date of discontinuation of collaboration with physician (*month, day, year*)	
Name of new collaborating physician			
Office address of new collaborating physician (*number and street, city, state, and ZIP code*)			
I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.			
Signature of certified direct entry midwife			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, 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 as a certified direct entry midwife.

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 such information.

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

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

AFFIRMATION

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

Signature of certified direct entry midwife	Date (*month, day, year*)

COLLABORATING PHYSICIAN'S STATEMENT

Name of collaborating physician (*last, first, middle*)		License number
Residence address (*number and street or rural route, city, state, and ZIP code*)		
Address of practice (*number and street or rural route, city, state, and ZIP code*)		
Residence telephone number ( )	Office telephone number ( )	E-mail address

Specialty	Board certification

CERTIFICATION OF COLLABORATION

Please indicate by signing your name below that the certified direct entry midwife named in this application will collaborate with you in accordance with IC 25-23.4-54 and 844 IAC 17.

Signature of collaborating physician	Date (*month, day, year*)