Reset Form

APPLICATION FOR LICENSURE AS A BACHELOR LEVEL SOCIAL WORKER (LBSW)

State Form 56783 (7-19)

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.*
2. *If applying for a temporary permit, please include your fee of $25.00 in accordance with 839 IAC 1-2-5.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *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	
Application Fee	Permit fee
Date fee paid *(month, day, year)*	Date fee paid (*month, day, year*)
Receipt number	Receipt number
Applicant number	Applicant number
License number	Temporary permit number
License issuance date *(month, day, year)*	Permit issuance date *(month, day, year)*

APPLICANT

Attach one (1) passport type quality photograph, no larger than 2" x 3", of yourself taken within the last eight (8) weeks. Do not attach a copy of your passport or driver's license photo.

DO NOT WRITE ABOVE THIS LINE

I am applying for a temporary permit: ☐ Yes ☐ No

I have previously made application for this profession in the State of Indiana under the name of:

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

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).

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

Please check all that apply:

☐ I am applying for licensure by examination.

☐ I am applying for licensure by exemption from the examination. I successfully passed the ASWB bachelor level examination, or a substantially equivalent examination, as indicated below.

Date (*month, day, year*): _____ State: _____

BACHELOR OF SOCIAL WORK DEGREE GRANTED BY:

Name of academic institution	Location (*city and state*)	Date BSW degree earned *(month, day, year)*

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS

Please list all places of professional employment, including self-employment.
You may add an additional sheet listing employment if more space is needed.

Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed *(month, year to month, year)*	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
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Duties or responsibilities		

OTHER STATE LICENSURE / CERTIFICATION

Do you now hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board? ☐ Yes ☐ No

(*If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated health occupation.*)

TYPE OF LICENSE / CERTIFICATE / REGISTRATION / PERMIT	STATE	LICENSE NUMBER	DATE ISSUED	STATUS
1.				
2.				
3.				
4.				
5.				

ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS.

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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 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 any regulated health occupation in any state *(including Indiana)* 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; ☐ 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

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 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

7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

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

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

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, 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 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 such information.

I further authorize the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, 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.

AFFIRMATION

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

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