Reset Form

APPLICATION FOR NURSING LICENSURE COMPACT LICENSE FOR REGISTERED AND LICENSED PRACTICAL NURSES LICENSED IN INDIANA

State Form 56932 (R1 / 3-25)

INDIANA STATE BOARD OF NURSING
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2043
E-mail: pla2@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $25.00, payable to the Indiana Professional Licensing Agency, in accordance with IC 25-23-1-11(d)(2) and IC 25-3-1-12(d)(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.

FOR OFFICE USE ONLY		
Compact application fee	Date fee paid (*month, day, year*)	Receipt number
Compact license number	Issuance date (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION	
Name (*last, first, middle, maiden*) *(Include any names EVER used.)*	Social Security number *
Address (*number and street or rural route, city, state, and ZIP code*)	Indiana license number
Date of birth (*month, day, year*)	Place of birth (*city and state*)
Daytime telephone number (*include area code*) ( )	E-mail address

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

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 health license, certificate, registration or permit you hold or have held in **any** state or country?	☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a nurse or **any** regulated health occupation in **any** state or country?	☐ Yes ☐ No
3. *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 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
4. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse or as another health care professional?	☐ Yes ☐ No
5. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No
6. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner?	☐ Yes ☐ No

DECLARATION OF PRIMARY STATE OF RESIDENCY

To be considered for a Compact license, Indiana must be your primary state of residency.

I declare Indiana as my primary state of residency and I am providing an Indiana address. ☐ Yes ☐ No

If you do not have a current Indiana malling address, you must provide one of the following documents showing Indiana to be your Primary State of Residence (PSOR):

- Driver's license with home address
- Voter registration card with home address
- W2 form declaring primary state of residence
- Federal income tax return including state of residence
- Military form number 2058 citing primary state of residence

Do you hold an active Nurse Licensure Compact (NLC) license In another state? ☐ Yes ☐ No

Please note, a nurse may only hold one Compact license. If you currently hold a Compact license in another jurisdiction and you are not changing your primary state of residency to Indiana you should not submit this application.

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 (*month, day, year*)

MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBER

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that disclosure of your U.S. Social Security number on your application is mandatory for the purpose of complying with IC 25-1-5-8 and IC 4-1-8-1 which provide that the Indiana Department of Revenue may obtain Social Security numbers from the Professional Licensing Agency for tax enforcement purposes. In addition, disclosing such number is mandatory in order for the licensing board or committee to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank 42 U.S.C. 1320(a)-7e(b), 5 USC 552a, 45 CFR Part 60.1, and 45 CFR Part 61.

Failure to disclose your U.S. Social Security number will result in the denial of your application. Application fees are not refundable.

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 nurse.

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 and the Indiana State Board of Nursing 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 the same.

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