Reset Form

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY NON-ECFMG TRAINING PERMIT

State Form 57691 (2-25)

MEDICAL LICENSING BOARD OF INDIANA
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. *Complete this form in its entirety.*
2. *This form can be mailed to the office address shown above.*
3. *Visit www.pla.IN.gov for more information.*

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY NON-ECFMG TRAINING PERMIT
(To be completed by the Hospital / Institution Chairman / Department Head.)

This is to certify that _____ is

enrolled in a postgraduate training program _____ in

the Department of _____

located at *(address)* _____

and will be obtaining training in Indiana at *(address)* _____.

This appointment is for the month and year beginning _____ and ending _____.

Name of Hospital Chairman / Department Head	Title	
Signature	Date of signature *(month, day, year)*	Telephone number

SUPERVISING PHYSICIAN ATTESTATION
(To be completed by physician monitoring work of permit holder.)

This is to attest that I, *(name)*_____, *(Indiana licenses number)* _____,

will monitor the work of *(permit holder name)* _____ during the course of

their training in Indiana under this permit.

Signature	Date of signature *(month, day, year)*	Telephone number

TRAINING LOCATIONS
(To be completed by the Hospital / Institution Chairman / Department Head.)

List all training locations under this permit.

NAME OF FACILITY	ADDRESS *(number and street, city, state, and ZIP code)*