Reset Form

POSTGRADUATE TRAINING VERIFICATION FOR A LIMITED LICENSE TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM

State Form 57740 (3-25)

INDIANA BOARD OF PODIATRIC MEDICINE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 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 address shown above.*
3. *Visit www.pla.in.gov for more information.*

This form is to be completed by the Hospital / Institution Chairperson / Department Head and submitted directly to the address below:

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PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
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This is to certify that _____ has been granted an appointment to serve at

_____ in the Department of _____

located at (*address*) _____

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

Printed name of Hospital Chairman / Department Head	Title
Signature of Hospital Chairman / Department Head	Date (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)	
Telephone number ( )	E-mail address