



**ADVANCED PRACTICE REGISTERED NURSE
COLLABORATIVE AGREEMENT SWORN STATEMENT**
State Form 9900383 (R1/12-25)
INDIANA PROFESSIONAL LICENSING AGENCY

**INDIANA STATE BOARD OF NURSING
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
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INSTRUCTIONS: 1. Complete this form in its entirety.
2. Submit this form online using Access Indiana single sign-on at <https://mylicense.in.gov/egov/ml1pla.html> or submit it by mail to the address above.

PRACTITIONER INFORMATION	
Name of Advanced Practice Registered Nurse (APRN):	Indiana APRN license number:
Name of Collaborator:	Indiana Collaborator License number:

SWORN STATEMENT	
Pursuant to IC 25-23-1-19.8(b)(2), we, the undersigned, hereby swear under penalties of perjury that we have operated within the terms of our Collaborative Practice Agreement and adhered to IC 25-23-1 and 848 IAC 5 between November 1, 2023, and October 31, 2025.	
Signature of APRN:	Date (month, day, year)
Signature of Collaborator:	Date (month, day, year)