



APPLICATION FOR LICENSURE AS A PHYSICAL THERAPIST OR PHYSICAL THERAPIST'S ASSISTANT

State Form 9111 (R18 / 9-17)

Approved by State Board of Accounts, 2017

**PHYSICAL THERAPY COMMITTEE
PROFESSIONAL LICENSING AGENCY**
 402 West Washington Street, Room W072
 Indianapolis, Indiana 46204-2724
 Telephone: (317) 234-8800
 E-mail: pla14@pla.IN.gov
www.pla.IN.gov

- INSTRUCTIONS:**
1. The fee for this application is \$100.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 6-2-2.
 2. If applying for a temporary permit, please include your fee of \$50.00 in accordance with 844 IAC 6-2-2
 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.

FOR OFFICE USE ONLY		
Application fee	Temporary permit fee	
Date fee paid (month, day, year)	Date fee paid (month, day, year)	
Receipt number	Receipt number	
Application number	License number	Temporary permit number
License issuance date (month, day, year)	Temporary permit issuance date (month, day, year)	

APPLICANT

Attach one (1) passport type quality photographs of yourself taken within the last eight (8) weeks. Please sign each photo at the bottom. Negatives and Polaroids are not acceptable.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle)		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 (required)	
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.)		
<input type="checkbox"/> I am a United States Citizen. <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an active duty member of the military? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No

BASIS FOR LICENSURE

Please check appropriate box.		Please check appropriate box.	
<input type="checkbox"/> Examination	<input type="checkbox"/> Endorsement	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Physical Therapist's Assistant
Have you previously filed an application for licensure/certification by examination or endorsement as a Physical Therapist or Physical Therapist's Assistant in Indiana or any other state? (If "Yes", please give details as to where and when.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you previously taken the licensure or certification examination for Physical Therapy or Physical Therapist's Assistant? (If yes, please list date and place.) <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you previously failed the licensure or certification examination in Indiana or any other state? (If "Yes", please give details as to where and when.) <input type="checkbox"/> Yes <input type="checkbox"/> No	

TEMPORARY PERMIT

Do you desire a temporary permit? Yes No

PHYSICAL THERAPIST / PHYSICAL THERAPIST'S ASSISTANT DEGREE GRANTED BY

Name of school	Location	Date of graduation (month, day, year)
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UNDERGRADUATE AND GRADUATE TRAINING

NAME OF SCHOOL	LOCATION	FROM (month, year)	TO (month, year)	DEGREE

List all states, **including Indiana**, in which you have been licensed or certified to practice any regulated health profession. Verification of all licenses listed must be submitted directly from the state licensing board.

STATE	TYPE OF LICENSE OR CERTIFICATE	NUMBER	DATE ISSUED (month, day, year)	CURRENT STATUS

PLACES OF EMPLOYMENT SINCE GRADUATION

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE (month, day, year)

PLACES YOU HAVE LIVED SINCE GRADUATION

GENERAL LOCATION	DATE (month, day, year)

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied licensure, registration or certification in any state (including Indiana) or country?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. <i>Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,</i> (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 <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been admonished, censored, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (month, day, year)
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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 physical therapy licensure or physical therapist's assistant certification.

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 to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application and I hereby specifically release the Agency and the Committee 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 (*month, day, year*)