Reset Form

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

State Form 9237 (R15 / 8-17)
Approved by State Board of Accounts, 2017

PHYSICIAN ASSISTANT COMMITTEE
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. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 2.2-2-8.*
2. *If applying for a temporary permit, please include a fee of $50.00, in addition to the $100.00 application fee, in accordance with 844 IAC 2.2-2-8.*
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.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Fee received	Temporary fee received	**APPLICANT**
Date received *(month, day, year)*	Date received (*month, day, year*)	*Attach one (1) passport type quality photographs of yourself taken within the last eight (8) weeks.*
Receipt number	Receipt number	
License number issued	Temporary permit number issued	
License issuance date *(month, day, year)*	Temporary permit issuance date *(month, day, year)*	

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	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

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.)*
☐ I am a United States Citizen. ☐ 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)*
☐ Yes ☐ No

Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐

Do you desire a temporary permit? ☐ Yes ☐ No | Are you applying for prescriptive authority under this physician? ☐ Yes ☐ No

BASIS FOR LICENSURE

☐ Endorsement ☐ Examination Date taking NCCPA examination *(month, day, year)*: _____

PHYSICIAN ASSISTANT DIPLOMA GRANTED BY

Name of school	Date of graduation *(month, day, year)*
Address of school *(number and street or rural route, city, state, and ZIP code)*	

NCCPA CERTIFICATE

Certificate number	Date granted *(month, day, year)*	Date of expiration *(month, day, year)*

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS

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

If your answer is "Yes" to any of questions 1 through 11, 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 you hold or have held?	☐ Yes ☐ No
2.	Have you ever surrendered or been denied a license, certificate, registration or permit to practice as a physician assistant or any regulated health occupation in any state *(including Indiana)* or country?	☐ Yes ☐ 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?	☐ Yes ☐ No
4.	Have you ever been the subject of an investigation by an authority regulating your profession?	☐ Yes ☐ No
5.	*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;	☐ Yes ☐ No
	(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☐ Yes ☐ No
	(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☐ Yes ☐ No
	(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☐ Yes ☐ No
	(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ Yes ☐ No
6.	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?	☐ Yes ☐ No
7.	Have you ever been admonished, censured, 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?	☐ Yes ☐ No
8.	Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No
9.	Have you ever been terminated or disciplined by your employer while practicing as a physician assistant or resigned in lieu of discipline?	☐ Yes ☐ No
10.	Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes ☐ No
11.	Have you ever been excluded from being a Medicare / Medicaid provider?	☐ Yes ☐ No
12.	Have you practiced as a Physician Assistant in the last three (3) years?	☐ Yes ☐ No

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM PHYSICIAN ASSISTANT SCHOOL

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

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 signed *(month, day, year)*

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 Physician Assistant.

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 Physician Assistant Committee from any and all liability in connection with such disclosure.

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 signed *(month, day, year)*

SUPERVISING PHYSICIAN'S STATEMENT

Name of supervising physician *(last, first, middle)*		License number
Residence address *(number and street or rural route, city, state, and ZIP code)*		
Address of practice *(number and street or rural route, city, state, and ZIP code)*		
Residence telephone number ( )	Office telephone number ( )	E-mail address
Specialty	Board certification	

SUPERVISORY AGREEMENT FOR THE PHYSICIAN ASSISTANT

INSTRUCTIONS: *ON AN ATTACHED SHEET, give a detailed description of the exact privileges and tasks the physician assistant shall be performing under the physician's supervision. In addition, please give a detailed description of the process maintained for evaluation of the physician assistant's performance. THIS SUPERVISORY AGREEMENT MUST BE ON COMPANY LETTERHEAD (including address, telephone number, and fax number), BE PERSON SPECIFIC, AND BE SIGNED BY BOTH THE PHYSICIAN ASSISTANT AND THE SUPERVISING PHYSICIAN.*

LIMIT ON PHYSICIAN ASSISTANT SUPERVISION

As a supervising physician, I understand that I may supervise no more than four (4) physician assistants at any one given time. Please indicate below the names and certificate numbers of all physician assistants you are currently supervising, if any. Use a separate sheet if necessary.

NAME OF PHYSICIAN ASSISTANT	LICENSE NUMBER

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the physician assistant named in this application will be under your continuous supervision in accordance with IC 25-27.5-6, IC 25-27.5-2-14 and 844 IAC 2.2, and that you shall review records of patient encounters maintained by the physician assistant as required by IC 25-27.5-6-1.

Signature of supervising physician	Date *(month, day, year)*