Reset Form

APPLICATION FOR LICENSURE AND/OR PRESCRIPTIVE AUTHORITY AS A PHYSICIAN ASSISTANT

State Form 9237 (R20 / 4-25)

PHYSICIAN ASSISTANT COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-5108
E-mail: pla5@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for the Physician Assistant 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. *There is no fee for the Prescriptive Authority.*
4. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
5. *All fees are non-refundable and non-transferable.*
6. *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.

FOR OFFICE USE ONLY				
Fee received	Date received *(month, day, year)*	Receipt number	License number issued	License issuance date *(month, day, year)*
Temporary fee received	Date received *(month, day, year)*	Receipt number	Temporary permit number issued	Temporary permit issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

Making application by: (*Check one*) ☐ Examination ☐ Reciprocity	Date taking NCCPA examination *(month, day, year)*	Do you desire a temporary permit? ☐ Yes ☐ No
Are you applying for prescriptive authority under the collaborating physician on page 3? ☐ Yes ☐ No	Physician assistant license number *(only if applying for prescriptive authority)*	
Are you applying for a Controled Substances Registration? ☐ Yes ☐ No	Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐	

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		
Social Security number *	Date of birth (*month, day, year*)	Gender ** ☐ Male ☐ Female
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

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)*	

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

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM PHYSICIAN ASSISTANT SCHOOL		
NAME AND ADDRESS *(number and street, city, state, and ZIP code)* OF EMPLOYER	**RESPONSIBILITIES**	**DATE** *(month, day, year)*

COLLABORATING PHYSICIAN'S INFORMATION *(If no collaborating physician, skip this section.)*		
Name of collaborating physician *(last, first, middle)*		License number
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

COLLABORATIVE 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 collaboration. THIS COLLABORATIVE AGREEMENT MUST BE ON COMPANY LETTERHEAD (including address, telephone number, and fax number), BE PERSON SPECIFIC, BE SIGNED BY BOTH THE PHYSICIAN ASSISTANT AND THE COLLABORATING PHYSICIAN, AND COMPLY WITH IC 25-27.5.*

QUESTIONS

If your answer is "Yes" to any of the following questions, explain fully in a signed written statement, 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. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, 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; (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 *nolo contendre* to any offense, misdemeanor, or felony in any state?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ 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

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.

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 information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency 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 affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)