APPLICATION FOR A TEMPORARY MEDICAL PERMIT
(For Postgraduate Training, Teaching, or Fellowship)

State Form 17598 (R13 / 6-13)
Approved by State Board of Accounts, 2013

MEDICAL LICENSING BOARD OF INDIANA
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

* Your Social Security number is being requested by this state agency in accordance with Indiana Code. 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

Permit fee	Date fee paid *(month, day, year)*	Receipt number
Permit number	Permit issuance date *(month, day, year)*	

Applicant

Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

Applying for: ☐ **Postgraduate training** ☐ **Teaching** ☐ **Fellowship**

APPLICANT INFORMATION

Name of applicant *(last, first, middle)*	Social Security number *
Check one ☐ MD ☐ DO	
Mailing address *(number and street or rural route)*	
City, State, and ZIP code	

Telephone number *(daytime)* ( )	Date of birth *(month, day, year)*	Ethnicity **	Race **	Gender ** ☐ Male ☐ Female
E-mail address			National Practitioner Identifier number	

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of school	Location	Date of graduation *(month, day, year)*

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED *(month, day, year)*

MEDICAL / OSTEOPATHIC EDUCATION

A foreign medical school must meet LCME standards at the time of graduation.

NAME OF SCHOOL	LOCATION	DATES ATTENDED *(month, day, year)*

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA
(*Include ALL internships, residencies and / or fellowships*)

All programs must have been ACGME accredited at the time of enrollment.

NAME OF SCHOOL	LOCATION	FROM *(month, year)*	TO *(month, year)*	ACGME ACCREDITED?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE *(month, day, year)*

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE *(month, day, year)*

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of the case / events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following, is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country, or surrendered your license?	☐ 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 a regulatory agency concerning your license?	☐ 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
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 surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes ☐ No
10. Have you ever been excluded from being a Medicare or Medicaid provider?	☐ Yes ☐ No
11. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐ Yes ☐ No
12. Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?	☐ Yes ☐ 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 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 temporary medical permit.

I hereby release the aforementioned persons, firms, officers, corporations, association, organization, 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 Board 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 signed *(month, day, year)*

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY MEDICAL PERMIT OR A TEMPORARY MEDICAL TEACHING PERMIT

(to be completed by the hospital / institution Chairman / Department Head)

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 and year beginning _____ and ending _____ .

Name of Hospital Chairman / Department Head	Title	
Signature	Date of signature *(month, day, year)*	Telephone number ( )