Reset Form

APPLICATION FOR PODIATRY LICENSE

State Form 27521 (R18 / 8-17)
Approved by State Board of Accounts, 2017

INDIANA BOARD OF PODIATRIC MEDICINE
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 $150.00, payable to the Indiana Professional Licensing Agency, in accordance with 845 IAC 1-6-9.*
2. *If applying for a temporary permit, please include your fee of $50.00 in accordance with 845 IAC 1-6-9.*
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 fee
Date fee paid *(month, day, year)*	Date temporary fee paid *(month, day, year)*
Receipt number	Receipt number
License issuance date *(month, day, year)*	Temporary issuance date *(month, day, year)*
License number	Temporary license number

Applicant

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

APPLICANT INFORMATION

Name of applicant *(last, first, middle)*		Social Security number *
Address of applicant (*number and street or rural route*)		City, state, and ZIP code
Daytime telephone number ( )	Evening telephone number ( )	E-mail address
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	

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	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

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

BASIS FOR LICENSURE

BASIS FOR LICENSURE - PLEASE CHECK ONE BOX BELOW.

☐ Examination
You are applying to take the APMLE Part III exam in Indiana.

☐ Endorsement of Examination
You have passed the APMLE Part III exam, you meet all other requirements for examination but you have not practiced podiatry for at least five (5) years in another state.

☐ Endorsement
You have passed the APMLE Part III exam, you meet all other requirements for examination and you have practiced podiatry for at least five (5) years in another state.

Do you desire a temporary permit? ☐ Yes ☐ No	Name of malpractice insurance carrier

PRE-PROFESSIONAL EDUCATION

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

PODIATRIC EDUCATION			
YEAR	**NAME OF SCHOOL**	**LOCATION**	**DATES ATTENDED** ***(month, day, year)***
1st			
2nd			
3rd			
4th			
5th			

PODIATRIC DEGREE GRANTED BY		
Name of school	Location	Date of graduation (*month, day, year*)

*List all Postgraduate Training, include **all** Preceptorships, Residencies and Fellowships.*

NAME OF HOSPITAL	**LOCATION**	**DATES** *(month / year)*: **FROM** **TO**

Do you hold or have you ever held a license, certificate, registration or permit to practice any regulated health occupations? ☐ Yes ☐ No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

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

List all places of employment since graduation. Endorsement candidates must submit proof of at least five (5) years of employment.

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

List all 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? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice podiatric medicine 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. *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
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? ☐ Yes ☐ 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? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties or perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date *(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 or its authorized representatives in connection with processing my application for podiatric 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 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 Board from any and all liability in connection with such disclosures.

A photostatic copy or 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)*