Reset Form

APPLICATION FOR LICENSURE TO PRACTICE PSYCHOLOGY IN INDIANA

State Form 27522 (R19 / 5-22)

STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:

1. *The application fee is $100.00 to apply by endorsement and examination, $50.00 to retake the national examination, or $75.00 to retake the jurisprudence examination. All application fees are to be payable to the Indiana Professional Licensing Agency, in accordance with 868 IAC 1.1-12-1.5.*
2. *If applying for a temporary permit, please include your fee of $50.00 in accordance with 868 IAC 1.1-12-1.5*
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.

FOR AGENCY USE ONLY

Date received *(month, day, year)*	Decision	Initials

PSYCHOLOGY LICENSE

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

TEMPORARY LICENSE

Application fee	Date fee paid *(month, day, year)*	Receipt number	Temporary license number	Temporary license issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

I wish to apply for licensure by (please check one): ☐ Examination ☐ Endorsement

Temporary license ☐ Yes ☐ No

If you are applying to retake an examination, please select the examination you are taking: ☐ National ☐ Jurisprudence

APPLICANT INFORMATION

Name of applicant *(last, first, maiden)*	Social Security Number*

Address *(number and street or rural route number)*	City, state, and ZIP code
Date of birth *(month, day, year)*	Gender ** ☐ Male ☐ Female
Telephone number *(daytime)* ( )	Email address

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). ☐ 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

e-Profile Identification number *(required: visit www.nabp.net)*	Total pharmacist intern hours	Pharmacist intern registration number	State issued	Date issued *(month, day, year)*

Name of school or college of pharmacy	Number of years attended	Date graduated *(month, day, year)*

STATES LICENSED

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

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

MASTER'S EDUCATION

Leave blank if not applicable.

Name of school	Department	Title of program

Dates attended *(month, day, year)*	Degree earned	Number of hours completed

GRADUATE EDUCATION (DOCTORAL)

Leave blank if not applicable.

Name of school	Department	Title of program

Dates attended *(month, day, year)*	Degree earned	APA approved at the time of graduation? ☐ Yes ☐ No

PREDOCTORAL INTERNSHIP

Was an internship required for graduation? ☐ Yes ☐ No	Name of internship program

Address of internship program *(number and street, city, state and ZIP code)*

APA / CPA approved at the time of completion? *If "No", please fill out page 4 and provide supplemental documents.* ☐ Yes ☐ No	APPIC approved at the time of completion? ☐ Yes ☐ No

Inclusive dates of internship *(month, day, year)*	Total hours worked	Director of internship training

POST DOCTORAL EDUCATION

Name of school

Department	Title of program	Dates attended *(month, day, year)*

POST DOCTORAL INTERNSHIP / FELLOWSHIP

Name of Internship / Fellowship

Address of Internship / Fellowship

Inclusive dates of Internship / Fellowship *(month, day, year)*	Total hours worked	Name of Supervising Psychologist

PROFESSIONAL IDENTITY BASED UPON DOCTORAL TRAINING

(Check only one or attach explanation)

☐ Clinical Psychology	☐ Experimental	☐ School	☐ Organizational / Industrial
☐ Counseling Psychology	☐ Developmental	☐ Social	☐ Other *(specify)*:

QUESTIONS

If your answer is "Yes" to any of the following, 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, or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice psychology, or any regulated health occupation in any state *(including Indiana)*? ☐ 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 contendere* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
5. Have you ever been denied staff membership 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, 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
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ 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 Board, or any of its authorized representatives in connection with processing 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 hereby swear or affirm that I have read the above statements and agree to same.

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

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SUPPLEMENTAL EDUCATION INFORMATION

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COURSEWORK INFORMATION

For graduates of doctoral programs that were not APA or CPA approved at the time of completion, please provide the following:
List the course number and course title of the graduate coursework you have completed in the required content areas as they appear on your transcript.
If the course titles as stated on your transcript do not clearly reflect the required content areas, provide additional supporting documentation such as course syllabus, term papers, etcetera. You may use the same course for more than one content area. Also, each content area may contain more than one course.

BIOLOGICAL BASES OF BEHAVIOR				
NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester Quarter

COGNITIVE-AFFECTIVE BASES OF BEHAVIOR				
NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester Quarter

SOCIAL BASES OF BEHAVIOR				
NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester Quarter

INDIVIDUAL DIFFERENCES				
NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester Quarter