Reset Form

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R20 / 10-16)
Approved by State Board of Accounts, 2016

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

INSTRUCTIONS:
1. *The fee for this application is $250.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 4-2-2.*
2. *If applying for a temporary permit, please include your fee of $100.00 in accordance with 844 IAC 4-2-2.*
3. *All fees are non-refundable and non-transferable.*
4. *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	
Application fee	Date fee paid (*month, day, year*)
Receipt number	Application number
License number	License issuance date (*month, day, year*)
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 (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)	Check one: ☐ MD ☐ DO	Social Security number *
Address of practice (*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
Mailing address (*number and street, city, state, and ZIP code*) *[if different from above]*				

E-mail address	National Provider Identifier number	ECFMG certificate number

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)* ☐

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☐ Yes ☐ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

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

Name of school	Location	Date of graduation *(month, day, year)*
Specialties	Board certification (*list ABMS certification*)	

EXAMINATION HISTORY

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

State where Board Exam was taken: _____

Examination	Most Recent Date Taken *(month/year)*	Results		Number of Attempts	Examination	Most Recent Date Taken *(month/year)*	Results		Number of Attempts
		Passed	Failed				Passed	Failed	
FLEX Pre-1985					NBOME Part II				
FLEX Component 1					NBOME Part III				
FLEX Component 2					COMLEX-USA Level 1				
LMCC - Single					COMLEX-USA Level 2, CE				
LMCC - Part I					COMLEX-USA Level 2, PE				
LMCC - Part II					COMLEX-USA Level 3				
NBME Part I					COMVEX				
NBME Part II					USMLE Step I				
NBME Part III					USMLE Step II, CS				
SPEX					USMLE Step II, CK				
NBOME Part I					USMLE Step III				

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 PROGRAM	LOCATION	FROM (*month, year*)	TO (*month, year*)	ACGME / AOA / RC ACCREDITED?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE *(month, day, year)*

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)		
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, REGARDLESS OF STATUS				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS

If your answer is "Yes" to any of questions 1 through 12, 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 been denied a license, certificate, registration or permit to practice medicine, 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 medicine 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;	☐ 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 surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes	☐ No
10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐ Yes	☐ No
11. Have you ever been excluded from being a Medicare / Medicaid provider?	☐ 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
13. Have you practiced as a MD/DO either clinically or administratively in the last three (3) years?	☐ 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 authorized, 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 medical 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 Board 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 same.

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