Reset Form

APPLICATION FOR LICENSURE AS A HEALTH FACILITY ADMINISTRATOR

State Form 42075 (R12 / 9-17)
Approved by State Board of Accounts, 2017

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-3022
E-mail: pla10@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 840 IAC 1-3-2.*
2. *If applying for a temporary permit, please include your fee of $50.00 in accordance with 840 IAC 1-3-2.*
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 OFFICE USE ONLY		
Application fee	Temporary permit fee	
Date fee paid (*month, day, year*)	Date fee paid (*month, day, year*)	
Receipt number	Receipt number	
License number	Temporary permit number	
Issuance date (*month, day, year*)	Issuance date (*month, day, year*)	
State exam fee	Date fee paid (*month, day, year*)	Receipt number

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)

Social Security number *

Date of birth (*month, day, year*)

Place of birth (*city and state or country*)

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 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

Are you requesting a temporary permit? ☐ Yes ☐ No ***You must have a current license in another State to qualify for a temporary permit.***

EDUCATION REQUIREMENT

This information must be verified by official transcript or notarized copy of your diploma. The specialized course of study must be verified by certificate. Please check one:

☐ I have a **BACCALAUREATE DEGREE** or higher from an accredited institution.
☐ I have an **ASSOCIATE DEGREE** in health care **and** took the **SPECIALIZED COURSE OF STUDY** prescribed by the board.
☐ I have taken the **SPECIALIZED COURSE OF STUDY** prescribed by the board.

ADMINISTRATOR-IN-TRAINING

*Please check all that apply below if you are **NOT** applying for a full waiver of the Administrator-In-Training program:*

☐ **I am requesting approval to enter the Administrator-In-Training program.** You must have your preceptor complete the preceptor application. The preceptor application must be approved before your health facility administrator application can be processed.

☐ **I am requesting approval to enter the Administrator-in-Training program and a waiver of a portion(s) of the Administrator-in-Training program.** Please attach a detailed letter of explanation and proof of experience in requested area.

WAIVER OF THE ADMINISTRATOR-IN-TRAINING PROGRAM

If you are applying for a waiver of the Administrator-In-Training program, please check one (1):

☐ **I have one (1) year of active work experience as a licensed health facility administrator in another state.** This experience must be verified by your employer on the "Verification of Employment" form. **Endorsement Candidates Only.**

☐ **I have completed a training program required for licensure as a health facility administrator in another state.** The Indiana State Board of Health Facility Administrators must determine that this program is equivalent to the Administrator-In-Training requirements in this state. You must have the state board complete the "Verification of Administrator-In-Training Program" form. **Endorsement Candidates Only.**

☐ **I have a master's degree in health care administration and six (6) months of active work experience as a licensed health facility administrator in another state.** Your education must be verified by transcript or by a notarized copy of your diploma. Your experience must be verified by your employer on the "Verification of Employment" form. **Endorsement Candidates Only.**

☐ **I have completed a residency-internship in health care administration completed as part of a degree requirement.** The Indiana State Board of Health Facility Administrators must determine that this is equivalent to the Administrator-In-Training requirements in this state. You must submit documentation verifying the residency / internship.

☐ **I have at least one (1) year of active work experience as a chief executive officer or chief operations officer in a hospital.** This experience must be verified by your employer on the "Verification of Employment" form.

WAIVER OF THE EDUCATION REQUIREMENT AND THE ADMINISTRATOR-IN-TRAINING PROGRAM

Please check the box below if applicable: **FOR ENDORSEMENT CANDIDATES ONLY**

☐ **I have two (2) years of active work experience as a licensed health facility administrator in another state.**
This must be verified by your employer on the "Verification of Employment" form.

EXAMINATION

All candidates for licensure in Indiana must complete the state jurisprudence examination. If your application is approved, you will receive instructions regarding preparation for the state examination. If you have completed the NAB examination, please fill in the information below:

Previously passed NAB exam in the state of	Date of exam *(month, day, year)*	What was your score? (*raw or scaled*)

POST-SECONDARY EDUCATION

NAME AND LOCATION OF SCHOOL	TYPE OF DEGREE / CERTIFICATE	DATE OF COMPLETION (*month, day, year*)

*List all states, **including Indiana**, in which you hold or have held a license, certificate, registration or permit to practice any regulated health occupation. Verification of all licenses are required to be submitted directly from the state licensing board.*

LICENSE TYPE	STATE	NUMBER	DATE OF ISSUE (*month, day, year*)	CURRENT STATUS

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 as a health facility administrator 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 subject to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a health facility administrator or as another healthcare professional? ☐ 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 information pertaining to the undersigned, requested by the Agency or any of its authorized representatives in connection with processing my application for licensure as a health facility administrator.

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 organizations, persons and institutions any information which is material to my application, and hereby specifically release the Agency and the 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)*