Reset Form

APPLICATION FOR LICENSURE AS A HEALTH FACILITY ADMINISTRATOR OR RESIDENTIAL CARE ADMINISTRATOR

State Form 42075 (R15 / 5-25)

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 for initial licensure 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 addition to the application fee in accordance with 840 IAC 1-3-2.*
3. *Applying to retake an examination fees are $50.00 for national exam or $100.00 for the jurisprudence exam, payable to the Indiana Professional Licensing Agency, in accordance with 840 IAC 1-3-2.*
4. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
5. *All fees are non-refundable and non-transferable.*
6. *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
License number	Date issued (*month, day, year*)	
Temporary permit fee	Date fee paid (*month, day, year*)	Receipt number
Temporary permit number	Date issued (*month, day, year*)	
State examination fee	Date fee paid (*month, day, year*)	Receipt number

DO NOT WRITE ABOVE THIS LINE

Type of application *(Select one.)*

- ☐ HFA Examination
- ☐ HFA Examination with AIT Waiver
- ☐ HFA Repeat Jurisprudence Exam
- ☐ RCA Examination
- ☐ HFA Reciprocity
- ☐ RCA Repeat Jurisprudence Exam
- ☐ HFA Repeat National Exam
- ☐ RCA Reciprocity

NOTE: If you are applying for the Health Facility Administrator or HFA license, you will provide information on this application specific to the HFA requirements. If you are applying for the Residential Care Administrator or RCA license, you will provide information on this application specific to the RCA requirements.

Do you wish to apply for a temporary permit? ☐ Yes ☐ No

Please note that you must have a current license in another State or territory of the United States to qualify for a temporary permit.

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)	
Social Security number *	Date of birth (*month, day, year*)
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 ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 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

ADMINISTRATOR-IN-TRAINING (AIT) INFORMATION

Please consult application instructions for documentation requirements in each situation provided.
Select one option and follow instructions if additional information is needed.

- ☐ I am requesting approval to enter the Administrator-in-Training (AIT) program.
- ☐ I am requesting approval to enter the Administrator-in-Training (AIT) program and waiver of a portion(s) of the AIT program.
- ☐ I wish to apply for only an Administrator-in-Training (AIT) program waiver. *You must select your situation from the selection below:*
  - ☐ One (1) year of active work experience as a licensed HFA / RCA in another state. ***Reciprocity Candidates Only.***
  - ☐ Completed AIT program or equivalent in another state. ***Reciprocity Candidates Only.***
  - ☐ Have a master's degree in health care administration and six (6) months of active work experience as a licensed HFA/RCA in another state. ***Reciprocity Candidates Only.***
  - ☐ Completed a residency-internship in healthcare administration completed as part of a degree requirement.
  - ☐ Have at least one (1) year of active work experience as a chief executive office or chief operations officer in a hospital.
- ☐ I wish to apply for the education AND full Administrator-in-Training (AIT) program waiver with two (2) years of active work experience as a(n) HFA / RCA in another state. ***Reciprocity Candidates Only.***

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 / RCAL examination, please fill in the information below:

Previously passed NAB / RCAL exam in the state of:	Date of exam *(month, day, year)*

POST-SECONDARY EDUCATION

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

LICENSE INFORMATION

*List all states, **including Indiana**, in which you hold or have held a license, certificate, registration or permit in healthcare administration.*
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

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, 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. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, 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

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 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 affirm, under penalties for perjury, that the foregoing representations are true.

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