Reset Form

VERIFICATION OF EMPLOYMENT OF APPLICANTS FOR HEALTH FACILITY ADMINISTRATOR LICENSURE

State Form 42352 (R7 / 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

* 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 FORM IS FOR RECIPROCITY CANDIDATES ONLY.

APPLICANT INFORMATION		
Name (*last, first, middle, maiden*)		Social Security number *
Address (*number and street, city, state, and ZIP code*)		
License number	Date of issuance (*month, day, year*)	Date of birth (*month, day, year*)
I hereby authorize _____ to furnish the Professional Licensing Agency with the information below.		
Signature of applicant		Date (*month, day, year*)

THE SECTION BELOW IS TO BE COMPLETED BY THE APPLICANT'S EMPLOYER		
Name of employer		
Name of facility where employed		
Address of facility (*number and street, city, state, and ZIP code*)		
Telephone number of facility ( )	Date employment began (*month, day, year*)	Date employment ended (*month, day, year*)
Position held		
Briefly describe duties of employee:		
Type of facility		Number of beds
Type of care offered		

If employee was disciplined in any way while in your employ, please provide certified copies of all related documents. Thank you for your assistance.

AFFIRMATION	
I hereby swear or affirm under penalties of perjury that the information provided herein is true and correct.	
Form completed by (*signature*)	Printed name and title
Name of firm or business	
Address of firm or business (*number and street, city, state, and ZIP code*)	
Telephone number ( )	Date (*month, day, year*)