Reset Form

VERIFICATION OF ADMINISTRATOR-IN-TRAINING PROGRAM

State Form 42353 (R7 / 1-16)

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

* 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 ENDORSEMENT 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*)

THIS SECTION IS TO BE COMPLETED AND AUTHORIZED BY THE STATE BOARD

☐ Yes ☐ No The individual referred to above completed an administrator-in-training program for licensure in our state. (*If yes, complete the section below.*)

Name of facility where training took place	Length of training program months hours
Address (*number and street, city, state, and ZIP code*)	
Preceptor / Supervisor of training program	

Type of program ☐ Residential Care ☐ Comprehensive Care	Type of facility	Please affix Board seal
Form completed by (*printed name*)		
Title		
Signature	Date (*month, day, year*)	