Reset Form

# APPLICATION FOR CHANGE OR ADDITION OF COLLABORATING PHYSICIAN FOR PHYSICIAN ASSISTANTS

State Form 42907 (R10 / 8-22)


**PHYSICIAN ASSISTANT COMMITTEE**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-5108
E-mail: pla5@pla.IN.gov
www.pla.IN.gov


*INSTRUCTIONS:*
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 2.2-2-8.*
2. *All fees are non-refundable and non-transferable.*
3. *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.

**FOR OFFICE USE ONLY**

| Date received (*month, day, year*) | Amount of fee received | Receipt number |
|---|---|---|
| | | |

| License number issued | Date of issuance (*month, day, year*) |
|---|---|
| | |

**DO NOT WRITE ABOVE THIS LINE**

**TO BE COMPLETED BY THE PHYSICIAN ASSISTANT (*Please print clearly in ink.*)**

| Name (*last, first, middle*) | Physician Assistant license number |
|---|---|
| | |

Address (*number and street or rural route*)

| City | State | ZIP code |
|---|---|---|
| | | |

| Social Security number * | Date of birth (*month, day, year*) | E-mail address | Telephone number (*daytime*) |
|---|---|---|---|
| | | | ( ) |

| Are you applying for a change of collaborating physician? | Are you adding a collaborating physician? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

Name of collaborating physician prior to completion of this application

| Name of new collaborating physician | Date of discontinuation of collaboration with physician (*month, day, year*) |
|---|---|
| | |

Office address of new collaborating physician (*number and street, city, state, and ZIP code*)

Specific reason for discontinuation of collaboration:

| Do you currently have prescriptive authority? | Are you applying for prescriptive authority under this physician? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

Name(s) of additional collaborating physician *(indicate all)*

Office address of additional collaborating physician (*number and street, city, state, and ZIP code*)

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.

| Signature of Physician Assistant | Date (*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 other 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 Physician Assistant.

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 the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force as the original.

**AFFIRMATION**

I hereby swear or affirm that I have read the above statements and agree to same.

| Signature of Physician Assistant | Date (*month, day, year*) |
|---|---|
| | |

| COLLABORATING PHYSICIAN'S INFORMATION | | | |
|---|---|---|---|
| Name of collaborating physician (*last, first, middle*) | | | License number |
| Residence address (*number and street or rural route, city, state, and ZIP code*) | | | |
| Address of practice (*number and street or rural route, city, state, and ZIP code*) | | | |
| Residence telephone number<br>(  ) | Office telephone number<br>(  ) | | E-mail address |
| Specialty | | Board certification | |

| COLLABORATIVE AGREEMENT FOR THE PHYSICIAN ASSISTANT |
|---|
| *INSTRUCTIONS: ON AN ATTACHED SHEET, give a description of the exact privileges and tasks the physician assistant shall be performing under the physician's collaboration. THIS COLLABORATIVE AGREEMENT MUST BE ON COMPANY LETTERHEAD, INCLUDING FACILITY ADDRESS AND TELEPHONE NUMBER, BE SPECIFIC TO THE APPLICANT, AND BE SIGNED BY BOTH THE PHYSICIAN AND THE PHYSICIAN ASSISTANT.* |