Reset Form

APPLICATION FOR ATHLETIC TRAINERS LICENSE

State Form 46715 (R17 / 2-25)

INDIANA ATHLETIC TRAINERS BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-3022
E-mail: pla10@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:

1. *The fee to apply for licensure as an athletic trainer is $55.00, payable to the Indiana Professional Licensing Agency, in accordance with 898 IAC 1-3-1.*
2. *If applying for a temporary permit when applying for licensure by examination or endorsement, please include a fee of $25.00, in addition to the $55.00 application fee, in accordance with 898 IAC 1-3-1.*
3. *If applying only for a temporary permit to practice athletic training for an event in Indiana while holding an active license as an athletic trainer in another state or territory of the United States, please include a fee of $25.00, in accordance with 898 IAC 1-3-1.*
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 and temporary permit 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. Social Security numbers are available to the Indiana Department of Revenue.
** 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*)	

DO NOT WRITE ABOVE THIS LINE

Applying for licensure by: ☐ Endorsement from another state ☐ Examination	Do you desire a temporary permit? ☐ Yes ☐ No	
If only applying for a temporary permit for an event in Indiana, provide the athletic trainer license information you currently hold with an active status in another state or territory of the United States	State / Territory	Expiration date (*month, day, year*)

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		
Social Security number *	Date of birth (*month, day, year*)	Gender ** ☐ Male ☐ Female
Address (*number and street or rural route number*)	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

ATHLETIC TRAINER EDUCATION

Pursuant to Indiana Code 25-5.1-3-1, applicants for licensure as an athletic trainer in the State of Indiana must show completion of accredited courses. Please indicate the institution at which you have completed the required courses. Official transcripts must be provided directly from each institution at which courses were completed or clinical experience was acquired.

Did you complete a CAAHEP / CAATE approved curriculum? ☐ Yes ☐ No	Name of institution
Type of degree received	
Located at (*city, state*)	Dates attended (*month, year*) From: To:

BOC CERTIFICATION

Date of certification *(month, day, year)*	Certification number	Date of expiration *(month, day, year)*	Is your certification current? ☐ Yes ☐ No

LICENSE INFORMATION

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

TYPE OF LICENSE	STATE	NUMBER	DATE ISSUED *(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 or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice athletic training or any regulated health occupation in any state (*including Indiana*), country, or US territory? ☐ 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 subjected to any restriction, probation or other type of discipline or limitations? ☐ Yes ☐ No

6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ 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*)

VERIFICATION OF SUPERVISION

Part of State Form 46715 (R16 / 11-20)

Applicants applying for a temporary permit, who have not taken the BOC examination, must practice under the supervision of an athletic trainer who is licensed by the State of Indiana during the ninety (90) days in which the temporary permit is valid.

Applicants must forward this form to the licensed athletic trainer who will be supervising the applicant. The form must be completed and submitted directly from the qualified supervisor.

This is to verify that _____ will be under my supervision while practicing athletic training. According to Indiana Code 25-5.1-3-8 (b), 898 IAC 1-1-9 and 898 IAC 1-4-1, I understand that I shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed. I understand that the patients care shall always be my responsibility. I also understand that it is my responsibility to maintain records of experiential hours for the person being supervised.

Beginning date *(month, day, year)*	Name of setting where supervision will occur

Address of setting where supervision will occur *(number and street, city, state, and ZIP code)*

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

Printed name of supervisor	Indiana license number of the supervisor	Telephone number
		( )

SUBMIT COMPLETED FORM BY E-MAIL TO pla10@pla.in.gov
OR BY MAIL TO:
INDIANA ATHLETIC TRAINERS BOARD
PROFESSIONAL LICENSING AGENCY
402 WEST WASHINGTON STREET, ROOM W072
INDIANAPOLIS, IN 46204

TEMPORARY PERMITS ARE NOT AVAILABLE ON A WALK-IN BASIS.

NOTE: According to IC 25-5.1-3-8, a temporary permit expires the earlier of: (1) the date the person holding the permit is issued a license; (2) the date the Board disapproves the person's application of licensure; or (3) ninety (90) days after the date of issuance of the temporary permit.

VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR ATHLETIC TRAINING LICENSURE APPLICANTS

Part of State Form 46715 (R16 / 11-20)

APPLICANT: Complete the top section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.

Name of applicant *(last, first, middle, maiden or given surname)*		
Address *(number and street or rural route, city, state, and ZIP code)*		
Social Security number *	Date of birth *(month, day, year)*	Telephone number *(daytime)* ( )

I hereby authorize _____ to furnish the Professional Licensing Agency with the information below.

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

The remainder of this form must be completed and submitted by the employer. Please submit the completed form by e-mail to pla10@pla.in.gov or by mail to: Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Name of employer
Name of business / institution where employed
Address of business / institution *(number and street, city, state, and ZIP code)*

Telephone number of business / institution ( )	Date employment began *(month, day, year)*	Date employment ended *(month, day, year)* *(If currently employed, please indicate)*
Number of hours applicant worked per week	Position held	E-mail address

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience. I do hereby declare that the information contained herein is true and correct.

Signature	Date *(month, day, year)*
Printed name	Title

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.