Reset Form

APPLICATION FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST (LMFT) OR A MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA)

State Form 50710 (R10 / 11-22)
Approved by the State Board of Accounts, 2017

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2054
E-mail: pla8@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 839 IAC 1-2-5.*
2. *If applying for a temporary permit, please include your fee of $25.00 in accordance with 839 IAC 1-2-5. Please note that only LMFT examination applicants are eligible to request the temporary permit per IC 25-23.6-8-1.5(b).*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *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	Permit fee
Date fee paid *(month, day, year)*	Date fee paid *(month, day, year)*
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date *(month, day, year)*	Permit issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

License Type:
☐ Marriage and Family Therapist ☐ Marriage and Family Therapist Associate

Obtained by Method: *Associate applicants must apply by examination.*
☐ Examination ☐ Reciprocity

Do you wish to apply for a temporary permit? *Only examination applicants are eligible to request the temporary permit. One (1) permit allowed per applicant.*
☐ Yes ☐ No

If you have passed a marriage and family therapy examination, provide the following information:

Date *(month, day, year):* _____ State: _____

Name of examination *(select one)* ☐ AAMFTRB ☐ State *(specify):* _____

APPLICANT INFORMATION

Name of applicant *(last, first, middle)*	Social Security number *
Date of birth *(month, day, year)*	Gender ** ☐ Male ☐ Female
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 one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 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? ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

GRADUATE EDUCTION (Master's or Doctoral)

Name of academic institution	Department	Program title
Location *(city and state)*	Dates attended *(mm/yy – mm/yy)*	Degree earned
Name of academic institution	Department	Program title
Location *(city and state)*	Dates attended *(mm/yy – mm/yy)*	Degree earned
Name of academic institution	Department	Program title
Location *(city and state)*	Dates attended *(mm/yy – mm/yy)*	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS

Please list all places of professional employment, including self-employment.

Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		

STATES LICENSED

List all states and territories, ***including Indiana***, in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state / territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	**State**	**Number**	**Date Issued** *(month, day, year)*	**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 pursuant to this application.

1.	Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold of have held?	☐ Yes	☐ No
2.	Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state *(including Indiana)*, country, or U.S. Territory?	☐ Yes	☐ No
3.	Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent 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 case facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline of 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)*

(Continued on the reverse side.)

FORM I VERIFICATION OF SUPERVISION FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

State Form 50710 (R10 / 11-22)

Complete **SECTION A** then forward this form to your previous or current supervisor(s) for completion of **SECTION B**. You must submit proof that you have acquired at least two hundred (200) hours of post-graduate clinical supervision comprised of at least one hundred (100) hours of individual supervision as described in IC 25-23.6-8-2.7. This supervision must be completed in no less than twenty-four (24) months while employed. If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** *(on the reverse side of this form)* for each previous supervisor. Sign the form(s) and return the form to the Professional Licensing Agency.

SECTION A / APPLICANT INFORMATION

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

Name *(last, first, middle)*	Date of birth *(month, day, year)*
Name of supervisor	Name of business / institution of supervisor
Supervisor title	Business address of supervisor *(number and street, city, state, and ZIP code)*
Applicants employer during time of supervision	

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

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

SECTION B / SUPERVISOR INFORMATION

SUPERVISOR: Complete the remainder of this form. Return the completed form directly to the Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Name of supervisor *(last, first, middle)*	State license / certificate number / type of license / certificate	
License / Certificate issued by	Name of business / institution of supervisor	Business telephone number ( )
Business address of supervisor *(number and street, city, state, and ZIP code)*		E-mail address
Number of years experience in Marriage and Family Therapy		
Applicant's job during the time of supervision	Applicant's employer during the time of supervision	
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*	
Total number of supervision hours completed	Number of hours of individual supervision	

Confirm direct service types provided under supervision per IC 25-23.6-8-2.7(b). Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

A. I was present at the applicant's place of work.	☐ True	☐ False
B. The applicant's place of work was at a different site but:		
(1) There was an equivalent supervisor on site.	☐ True	☐ False
(2) The applicant was not engaged in independent private practice.	☐ True	☐ False
C. The applicant's virtual supervision was no more than fifty percent (50%) of the total supervision.	☐ True	☐ False

Brief description of how supervision was conducted:

The above indicated supervision was performed by me pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

Signature of Supervisor:	Title:
Printed Name of Supervisor:	Date *(month, day, year)*:

FORM I VERIFICATION OF SUPERVISION FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS *(continued)*

Part of State Form 50710 (R10 / 11-22)

SECTION C / AFFIRMATION OF SUPERVISION

To be completed by applicant if your previous supervisor is no longer able to complete ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why your previous supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one (1) previous supervisor, this form may be duplicated but you must submit one (1) AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason why your previous supervisor is no longer able to complete SECTION B.

My previous supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of supervisor *(last, first, middle, maiden)*	License number

Applicant's job duties during the time of supervision:	Applicant's employer during the time of supervision:
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*
Total number of supervised hours	Number of hours of individual supervision

Confirm direct service types provided under supervision per IC 25-23.6-8-2.7(b). Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

Brief description of how supervision was conducted

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

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

(Continued on the reverse side.)

FORM II VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 50710 (R10 / 11-22)

Complete **SECTION A** then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have completed one thousand (1000) hours of post-graduate clinical experience, during which at least fifty percent (50%) of your clients were receiving marriage and family therapist services. This clinical experience must be obtained in no less than twenty-four (24) months. **This form may be duplicated if your experience was completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** *(on the reverse side of this form)* for each previous employer. Sign the form(s) and return the form to the Professional Licensing Agency at 402 West Washington Street, Room W072, Indianapolis, IN 46204.

SECTION A / APPLICANT INFORMATION

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

Name *(last, first, middle)*	Date of birth *(month, day, year)*

Employer's name of business	Employment Business Address *(number and street, city, state, and ZIP code)*
Name of supervisor	Supervisor title

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

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

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

SUPERVISOR: Complete the remainder of this form. Return the completed form directly to the Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Name of employer *(last, first, middle)*

Name of business / institution where employed	Business E-mail address

Business address *(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*

Average hours worked per week	Total clinical hours earned	Total relational hours earned

Provide a brief description of job duties:

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 of Employer	Title
Printed Name of Employer	Date *(month, day, year)*

(Continued on the reverse side.)

FORM II VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS *(continued)*

Part of State Form 50710 (R10 / 11-22)

SECTION C / AFFIRMATION OF EXPERIENCE

*To be completed by applicant if your previous employer is no longer able to complete **SECTION B** (on reverse side of this form). Please indicate below the reason why your previous employer is no longer able to complete **SECTION B** (on the reverse side of this form). **If you are affirming supervision received from more than one (1) previous employer, this form may be duplicated but you must submit one (1) AFFIRMATION OF SUPERVISION for each previous employer that is no longer able to complete SECTION B (on the reverse side of this form).***

I am unable to have my previous employer(s) complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of employer

Name of business / institution where employed

E-mail address

Business address *(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

Position held

Number of hours of applicant worked per week

Total clinical hours

Total relational hours

Confirm direct service types provided at this location. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

Brief description of job duties

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

Signature of applicant

Date *(month, day, year)*

(Continued on the reverse side.)

FORM III – A VERIFICATION OF MARRIAGE AND FAMILY THERAPIST (LMFT) AND MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA) COURSEWORK

Part of State Form 50710 (R10 / 11-22)

All information on this form must be typed or clearly printed. This is a two (2) page form.				
Please list the course titles in the areas indicated below as they appear on your transcript, that in your opinion, meet the following requirements. If two or more courses combined meet the criteria, list all courses that may apply.				
Theoretical Foundations of Marriage and Family Therapy				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Major Models of Marriage and Family Therapy				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Individual Development				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Family Development and Family Relationships				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Clinical Problems				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Collaboration with Other Disciplines				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Sexuality				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Gender and Sexual Orientation				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Issues of Ethnicity, Race, Socioeconomic Status, and Culture				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Therapy Techniques				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter

(Continued on the reverse side)

Behavioral Research That Focuses on the Interpretation and Application of Research Data as it Applies to Clinical Practice				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
The previously mentioned content areas may be combined into any one (1) graduate level course.				
Legal, Ethical, and Professional Standards Issues in the Practice of Marriage and Family Therapy				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Appraisal and Assessment for Individual or Interpersonal Disorder or Dysfunction				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter

I, the undersigned applicant for marriage and family therapist's license, do hereby certify that I have also completed the following:

A specified clinical practicum, internship or field experience in marriage and family therapy of at least five hundred (500) hours of face-to-face client hours with individuals, couples and families for the purpose of assessment and intervention, that was conducted over a period of one (1) year at an average rate of ten (10) hours of clinical contact per week. Of the five hundred (500) hours, no more than fifty percent (50%) of this time was spent with individuals. This practicum also included a minimum of one hundred (100) hours of supervision administered by a licensed marriage and family therapist who has at least five (5) years of experience as a qualified supervisor.

The following graduate work may NOT be used to satisfy the content area requirements above:

(1) Thesis or Dissertation Work
(2) Practicum, Internships, or Field Work

Signature of applicant	Date *(month, day, year)*
Printed name of applicant	Date of Birth:

(Continued on the reverse side)

FORM III - B
GRADUATE COURSEWORK CONTENT AREAS
Part of State Form 50710 (R10 / 11-22)

THEORETICAL FOUNDATIONS OF MARRIAGE AND FAMILY THERAPY
Studies that provide an understanding of the epistemology of family therapy.
A. Theories of individual and family development and transitions across the life-span
B. Theories of family therapy

MAJOR MODELS OF FAMILY THERAPY
Studies that provide an understanding of clinical practices and treatments of Family Therapy.
A. Structural and Strategic Family Therapy
B. Brief Family Therapy
C. Solution Oriented Family Therapy
D. Narrative Family Therapy

INDIVIDUAL DEVELOPMENT
Studies that provide an understanding of a person's development.
A. Life-span human development
B. Child psychology and development
C. Adolescent developmental stages
D. Adult in mid-life or menopausal women, etc.

FAMILY DEVELOPMENT AND FAMILY RELATIONSHIPS
Studies that provide an understanding of family development and varying relationships within the family.
A. Advanced family studies,
B. Family stages during the life cycle

CLINICAL PROBLEMS
Studies that provide an understanding of problems affecting a family system
A. Treating the abusing family
B. Family treatment of incest
C. Clinical treatment of alcoholism and other addictions in the family
D. Helping a family cope with crisis

COLLABORATION WITH OTHER DISCIPLINES
Studies that provide an understanding of family therapy approaches cooperating with other professionals
A. Behavior disorders
B. Medical management and family therapy in ADD and ADHD
C. Psychological Testing and how it relates to borderline families
D. Family therapy in a school setting

SEXUALITY
Studies that provide an understanding of sexuality in the family.
A. Human sexuality
B. Treating sexual dysfunction
C. Principles, practices, and applications of sexual abuse treatment

GENDER AND SEXUAL ORIENTATION
Studies that provide an understanding of the range of sexual differences.
A. Human sexuality
B. Gender and transgender clinical problems
C. Comparing and contrasting treatment regarding issues of heterosexuality, bisexuality and homosexuality
D. Homosexual and bisexual couples and families

ISSUES OF ETHNICITY, RACE, SOCIOECONOMIC STATUS AND CULTURE
Studies in this area include, but are not limited to, the following:
A. Special clinical problems pertaining to treatment of African American, Asian and Hispanic families
B. Clinical problems of the working poor
C. First generation immigrant families

(Continued on the reverse side.)

THERAPY TECHNIQUES

Studies in this area include, but are not limited to, the following:

A. Family therapy skills
B. Family sculpting
C. The use of genograms in family therapy

BEHAVIORAL RESEARCH THAT FOCUSES ON THE INTERPRETATION AND APPLICATION OF RESEARCH DATA

Studies in this area include, but are not limited to, the following:

A. Research methods in child and family studies
B. Qualitative research in marriage and family studies

LEGAL, ETHICAL, AND PROFESSIONAL STANDARDS AND ISSUES IN THE PRACTICE OF MARRIAGE AND FAMILY THERAPY

A. Professional issues in marriage and family therapy
B. Ethical issues in marriage and family therapy

APPRAISAL AND ASSESSMENT FOR INDIVIDUAL OR INTERPERSONAL DISORDER OR DYSFUNCTION

A. The use of the DSM in diagnosis
B. Comparing and contrasting the GAF and the GARF

(Continued on the reverse side)

FORM P – 1 VERIFICATION OF PRACTICUM FOR MARRIAGE AND FAMIY THERAPY ASSOCIATE (LMFTA) AND MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 57010 (R10 / 11-22)

INSTRUCTIONS: 1. *The applicant must complete Section A, then forward to the educational institution at which the practicum was completed*
2. *Section B must be completed by an official of the institution that has granted the academic credit for this supervised clinic.*

SECTION A – APPLICANT INFORMATION	
Name of applicant *(last, first, middle, maiden or previous)*	Date of Birth:
My minimum five hundred (500) hour practicum was completed under the auspices of the following education institution:	
Name of institution	
Location *(city and state)*	
Date practicum began *(month, year)*	Date practicum was completed *(month, year)*
I completed the practicum at the following location:	
Specific location of field experience	

SECTION B – VERIFICATION OF COMPLETION OF FIVE HUNDRED (500) HOUR PRACTICUM

As an official of the school named above, I certify that the above-named applicant has completed at least the following experience during the completion of the practicum:

1. The applicant has completed at least five hundred (500) hours of marriage and family therapy services, including four hundred (400) face-to-face client hours, of which at least two hundred (200) hours must be relational, under to supervision of a licensed marriage and family therapist who has at least five (5) years of experience as a qualified supervisor approved by the Board.
2. The applicant has received at minimum of at least one hundred (100) hours of supervision from a licensed marriage and family therapist who has at least five (5) years experience as a qualified supervisor.
3. The applicant has conducted the required five hundred (500) hours over a period of one (1) year, at an average rate of ten (10) hours of clinical contact per week and no more than fifty percent (50%) of this time was spent with individuals.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the practicum. For the purposes of this certification, individual supervision is supervision rendered to not more than two (2) individuals at a time and group supervision is supervisions rendered to at least two (2) and not more than ten (10) individuals at a time. During the completion of this practicum, the applicant did receive the following number of hours of supervision: _____

I further certify that the supervision for this practicum was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape, and / or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s). *(Provide name(s) and qualifications below.)*

Signature of school official	Date *(month, day, year)*
Printed name of school official	Title of school official
Name of program faculty member	Name of alternate supervisor
Name of site supervisor	Position held at the institution
Name of the institution	
Name of applicant *(last, first, middle, maiden or previous)*	

Return this completed form to:

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204