Reset Form

APPLICATION FOR PRECEPTOR

State Form 49845 (R8 / 11-20)

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

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 840 IAC 1-3-2.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY		
Application fee	Date fee paid (*month, day, year*)	Receipt number
Preceptor number	Date issued (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

ADMINISTRATOR-IN-TRAINING (AIT) INFORMATION
Name of AIT (*last, first, middle, maiden*)
Address of AIT (*number and street, city, state, and ZIP code*)
Type of program *(Select one.)* ☐ HFA Administrator-in-Training program ☐ RCA Administrator-in-Training program

PRECEPTOR APPLICANT INFORMATION		
Name *(last, first, middle, maiden)*	Social Security number *	Date of birth (*month, day, year*)
Residential address *(number and street or rural route, city, state, and ZIP code)*		
Telephone number *(Daytime)* ( )	Email address *(required)*	
RCA / HFA license number	Original issuance date (*month, day, year*)	Expiration date (*month, day, year*)
Name of training facility		Facility telephone number ( )
Address of facility (*number and street, city, state, and ZIP code*)		
Type of facility		

PRECEPTOR WORK EXPERIENCE
List below all of your work experience for the past three (3) years, starting with your present employment. ***INCLUDE YOUR EMPLOYER, POSITION, TYPE OF BUSINESS, PERIOD OF TIME WORKED, DUTIES, TYPE OF FACILITY (SNF, ICF, ETC.) AND NUMBER OF BEDS IN THE FACILITY.***

LICENSE INFORMATION

Have you ever been qualified as a Preceptor in another state?

☐ Yes ☐ No

If yes, list the state, date of issuance and expiration date *(month, day, year)*

QUESTIONS

If your answer is **"yes"** to any of the following, explain fully in a signed written statement, including all related details. Include the violation, location, date and disposition. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to the application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a health facility administrator or any regulated health occupation in **any** state, country, or US 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;
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state;
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or
   (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 restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a health facility administrator or as another health care professional? ☐ 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*)