Reset Form

APPLICATION FOR PRECEPTOR

State Form 49845 (R7 / 4-15)
Approved by State Board of Accounts, 2015

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: Please print or type legibly.

* 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 INFORMATION
Name of A.I.T. (*last, first, middle, maiden*)
Address of A.I.T. (*number and street*)
City, state, and ZIP code

PRECEPTOR APPLICANT INFORMATION			
Name *(last, first, middle, maiden)*			*Social Security number
Residential address *(number and street or rural route)*			
City, state, and ZIP code		Email address *(required)*	
Telephone number *(Daytime)* ( )	Date of birth (*month, day, year*)	Place of birth *(city, state or foreign country)*	
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*)		Type of facility	
City, state, and ZIP code			

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.***

(*Continued on the reverse side*)

PRECEPTOR WORK EXPERIENCE (*continued*)

List all other related experience pertaining to the health facility, administration, and/or other related areas:

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)*

If your answer is **"yes"** to any of the following, explain fully in a sworn affidavit, 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 or country? ☐ 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 any health care professional? ☐ Yes ☐ No

VERIFICATION

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

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