Reset Form

APPLICATION FOR LICENSURE BY EXAMINATION FOR GRADUATES OF U.S. NURSING SCHOOLS

State Form 50024 (R8 / 9-17)
Approved by State Board of Accounts, 2017

INDIANA STATE BOARD OF NURSING
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2043
E-mail: pla2@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 848 IAC 1-1-14.*
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.*

* 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

Application fee	Date fee paid (*month, day, year*)	Receipt number

License number	Issuance date (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

Are you applying for a license as a:
☐ Registered Nurse ☐ Licensed Practical Nurse

Have you taken the NCLEX examination previously?
☐ Yes, repeat applicant ☐ No, first time taking the examination

If Yes, list the date(s) and state where taken:

APPLICANT INFORMATION

Name (*last, first, middle, maiden*)	List other last names you have used	Social Security number*

Street address (*number and street or rural route*)	City, state, and ZIP code

Date of birth (*month, day, year*)	Place of birth (*city and state*)

Telephone number (*include area code*)	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).

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

Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐

NURSING EDUCATION

* ***DO NOT USE THIS APPLICATION IF YOU GRADUATED FROM A NURSING PROGRAM OUTSIDE OF THE UNITED STATES. A FOREIGN GRADUATE EXAMINATION APPLICATION CAN BE DOWNLOADED AT www.pla.IN.gov .***

Name of nursing school

Location (*city and state*)	Date of enrollment (*month, day, year*)	Date of graduation (*month, day, year*)

Check the type of program from which you graduated.
☐ **RN PROGRAM** ☐ Associate Degree (2 year) ☐ Baccalaureate Degree (4 year) ☐ Diploma (3 year) ☐ **PN PROGRAM**

HIGH SCHOOL EDUCATION

Name of school

Location (*city and state*)

Date of graduation (*month, day, year*)	If you are not a high school graduate, have you taken and passed the GED? (*If yes, submit an official copy of your GED scores.*) ☐ Yes ☐ No

Do you hold, or have you ever held, a license, certificate, registration or permit to practice nursing and/or any other regulated health occupation? ☐ Yes ☐ No

List all states, including Indiana, foreign territories, or countries, in which you hold or have held a license, certificate, registration or permit to practice nursing and/or any other regulated health occupation.

LICENSE TYPE	STATE / COUNTRY / TERRITORY	NUMBER	DATE OF ISSUE *(month, day, year)*	STATUS

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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 you hold or have held in **any** state or country? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice as a nurse or **any** regulated health occupation in **any** state or country? ☐ Yes ☐ No

3. *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

4. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse or as another health care professional? ☐ Yes ☐ No

5. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

6. 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

REPEAT APPLICANTS ONLY: If your answer was "Yes" to any of the above questions, and your detailed statement was submitted to the State of Indiana with your original application and has not changed, please initial here: _____

You only need to submit additional information if circumstances have changed since you last submitted a detailed statement regarding the above questions.

APPLICATION AFFIRMATION

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

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

MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBER

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that disclosure of your U.S. Social Security number on your application is mandatory for the purpose of complying with IC 25-1-5-11, IC 25-1-6-10 and IC 4-1-8-1 which provide that the Indiana Department of Revenue may obtain Social Security numbers from the Professional Licensing Agency for tax enforcement purposes. In addition, disclosing such number is mandatory in order for the licensing board or committee to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank 42 U.S.C. §1320(a)-7e(b), 5 USC, §552a, 45 CFR Part 60.1, and 45 CFR Part 61.

Failure to disclose your U.S. Social Security number will result in the denial of your application. Application fees are not refundable.

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 nurse.

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 and the Indiana State Board of Nursing 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 hereby swear or affirm that I have read the above statements and agree to the same.

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

PLEASE TAPE YOUR PHOTOGRAPH BELOW (*DO NOT STAPLE*)

(*You must place your signature, the program director's signature and the school seal on the front of your photograph.*)

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CERTIFICATE OF COMPLETION

☐ **RN** ☐ **LPN**

*I hereby certify that*_____ *was admitted to the* _____ *Program of Nursing located in* _____ *on* _____ *and completed requirements for graduation on* _____ *will/did graduate on* _____ . *His/Her Social Security number is* _____ .

There is evidence in our permanent records that this person has met the requirements as specified in Indiana law.

*DATE:*_____ *SIGNED* _____
Signature

_____
Printed Name

SCHOOL SEAL

_____
Dean / Director / Designee

APPLICANT: *The* ***CERTIFICATE OF COMPLETION*** *form must be completed and sent to the Professional Licensing Agency by your program of nursing. You will not be declared eligible to take the examination until this form is received by the Agency.*

DIRECTOR OF PROGRAM: *The applicant cannot be declared eligible to take the examination until this form is received by the Professional Licensing Agency.* ***CERTIFICATES OF COMPLETION SHOULD NOT BE SENT TO THE PROFESSIONAL LICENSING AGENCY UNTIL THE APPLICANT HAS COMPLETED THE PROGRAM OF NURSING.***