



# APPLICATION FOR PRESCRIPTIVE AUTHORITY AS AN ADVANCED PRACTICE REGISTERED NURSE

State Form 50025 (R8 / 5-20)

**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 5-3-1.
  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](http://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
Prescriptive authority number	Date of issuance (month, day, year)	

**DO NOT WRITE ABOVE THIS LINE**

Please check one of the following indicating the category of Advanced Practice Registered Nurse:

Clinical Nurse Specialist     
 Nurse Practitioner     
 Certified Nurse Midwife     
 Certified Registered Nurse Anesthetist

Area of practice / specialty

**Please check one below and provide requested information.**

I am applying for initial Registered Nurse (RN) licensure in Indiana.

I hold an active Indiana RN license.      License number: \_\_\_\_\_

**OR**

I hold an active National Licensure Compact - RN License in another State.      State: \_\_\_\_\_

Compact - RN license number: \_\_\_\_\_      Date of expiration (month, day, year): \_\_\_\_\_

APPLICANT INFORMATION	
Name (last, first, middle, maiden) (include any names EVER used)	Social Security number*
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 ONLY ONE of the following.)	
<input type="checkbox"/> I am a United States Citizen. <input type="checkbox"/> I am a qualified alien (as defined under 8 USC § 1641). <input type="checkbox"/> 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)	Are you an active duty member of the military? (Optional)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. (Optional) <input type="checkbox"/>	

LIST ALL CURRENT OFFICE ADDRESSES AND TELEPHONE NUMBERS				
NUMBER AND STREET	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				(      )
				(      )
				(      )
				(      )
				(      )

**LIST ALL NURSING EDUCATION**

NAME OF SCHOOL	LOCATION	DATES ATTENDED	DEGREE(S) GRANTED

**LIST ALL NAMES AND ADDRESSES OF EMPLOYERS AND RESPONSIBILITIES HELD OR PERFORMED SINCE GRADUATION FROM NURSING SCHOOL**


**LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED, CERTIFIED, OR REGISTERED TO PRACTICE ANY REGULATED HEALTH OCCUPATION**

STATE	PROFESSION	NUMBER ISSUED	DATE ISSUED <i>(month, day, year)</i>	STATUS

**LIST THE NAME AND LICENSE NUMBER OF THE COLLABORATING PHYSICIAN(S)**

NAME	LICENSE NUMBER

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 <b>any</b> state or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice as a nurse or <b>any</b> regulated health occupation in <b>any</b> state or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <i>Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,</i> (1) have you ever been arrested;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	<input type="checkbox"/> Yes <input type="checkbox"/> No
(5) have you ever pled <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>APPLICATION AFFIRMATION</b>	
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)

<b>AUTHORIZATION TO RELEASE INFORMATION</b>
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 prescriptive authority as an Advanced Practice Registered 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.

<b>AFFIRMATION</b>	
I hereby swear or affirm that I have read the above statements and agree to the same.	
Signature of applicant	Date (month, day, year)