



# APPLICATION FOR A LIMITED LICENSE TO PRACTICE NURSE-MIDWIFERY

State Form 50026 (R5 / 7-16)

Approved by State Board of Accounts, 2016

**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 3-5-1.  
 2. All fees are non-refundable and non-transferable.  
 3. Please refer to the instructions on our website at [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
License number	Date of issuance (month, day, year)	

### DO NOT WRITE ABOVE THIS LINE

### APPLICANT INFORMATION

Name (last, first, middle, maiden) (include any names EVER used)

Address (number and street or rural route, city, state, and ZIP code)

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

Social Security number \*      E-mail address      Telephone number (include area code)  
 (      )

Are you the spouse of a member of the military who is assigned to a duty station in Indiana (Optional)?       Yes       No

### SCHOOL OF NURSING

NAME OF SCHOOL	LOCATION	DATES ATTENDED	DEGREE(S) GRANTED

### SCHOOL OF MIDWIFERY

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 AND MIDWIFERY SCHOOLS

-----

-----

-----

-----

-----

-----

**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 (month, day, year)	Status

Have you taken and passed the National Certification Examination given by the American College of Nurse-Midwives?  Yes  No

If "Yes", list the date and location:

Have you ever failed the National Certification Examination given by the American College of Nurse-Midwives?  Yes  No

If "Yes", list the date and location:

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, nurse midwife 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 contendere* 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

**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)

**AUTHORIZATION TO RELEASE 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 limited license to practice nurse-midwifery.

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**  
*(You must place your signature on the front of your photograph.)*