Reset Form

APPLICATION FOR LICENSURE BY EXAMINATION FOR GRADUATES OF FOREIGN NURSING SCHOOLS

State Form 50023 (R7 / 8-17)
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	Date of issuance (*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 ☐ No

If Yes, when and in what state?

APPLICANT INFORMATION

Name (*last, first, middle, maiden*) (*include any names EVER used*)	Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state*)
Address (*number and street or rural route, city, state, and ZIP code*)	
Daytime 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

Name of nursing school	Length of program

Date of entrance (*month, day, year*)	Date of completion (*month, day, year*)	Date of graduation (*month, day, year*)

You must submit an **OFFICIAL** or **NOTARIZED** copy of your nursing school transcripts, separated into clinical and theory hours or days.

HIGH SCHOOL EDUCATION

Name of school

Location

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 any 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 any regulated health occupation.

License Type	State / Country / Territory	Number	Date of Issue *(month, day, year)*	Status

COMMISSION ON GRADUATES OF FOREIGN NURSING SCHOOLS EXAMINATION

Have you taken and passed the Commission on Graduates of Foreign Nursing Schools Examination? ☐ Yes ☐ No	If your answer is "**Yes**", provide the date you took the examination (*month, day, year*).

The CGFNS must send evidence that you passed the examination directly to the Professional Licensing Agency.

If your answer is "**No**", you MUST TAKE AND PASS this examination before taking the registered nurse examination, and have the Commission submit such proof directly to the Professional Licensing Agency. For information regarding the CGFNS examination, please contact:

Commission on Graduates of Foreign Nursing Schools
3600 Market Street, Suite 400
Philadelphia, PA 19104-2651
Telephone: (215) 349-8767
www.cgfns.org

** Applicants who have completed a practical nursing program are not required to take the CGFNS examination.

NOTICE: If you completed a registered nurse program or the equivalent (*2-4 year program*) in a foreign country, you will only be eligible for a REGISTERED NURSE licensure. Foreign educated registered nurses are not eligible for practical nursing licensure in Indiana.

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

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*)

APPLICANT

Please attach two (2) passport-quality photograph taken not earlier than eight (8) weeks prior to the date of application, dated and signed across the back in the applicant's handwriting, "I certify that this is a true photograph of myself".

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*)