Reset Form

APPLICATION FOR LICENSURE AS A NURSE

State Form 50027 (R11 / 5-25)

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. *If applying for a temporary permit, please include your fee of $10.00 in accordance with 848 IAC 1-1-14.*
3. *If applying for the Compact license, please include your fee of $25.00 in accordance with IC 25-23-1-11(d)(2) and IC 25-3-1-12(d)(2).*
4. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
5. *All fees are non-refundable and non-transferable.*
6. *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*)
Permit fee	Date fee paid (*month, day, year*)	Receipt number	Permit number	Issuance date (*month, day, year*)
Compact application fee	Date fee paid (*month, day, year*)	Receipt number	Compact license number	Issuance date (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

Are you applying for a license as a:
☐ Registered Nurse (RN) ☐ Licensed Practical Nurse (LPN)

Do you desire a temporary permit? ☐ Yes ☐ No

If Yes, you **must** submit the temporary application permit fee and proof of CURRENT / ACTIVE licensure in another state, along with the application and fee for the permanent license.

By *(check one)*:
☐ Examination ☐ Endorsement

Please indicate original state of licensure

Have you previously filed an application for licensure in the State of Indiana? ☐ Yes ☐ No

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:

Do you wish to apply for the Nursing Licensure Compact (NLC) license? ☐ Yes ☐ No

APPLICANT INFORMATION

Name (*last, first, middle, maiden*)

List any other last 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 ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ 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)* ☐ 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

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

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

Length of program

Check the type of program from which you graduated.
☐ Associate Degree ☐ Bachelor of Science ☐ RN Program Three (3) Year Diploma ☐ PN Program ☐ Foreign Nursing School Graduate *

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? ☐ 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, 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	NUMBER	DATE OF ISSUE *(month, day, year)*	STATUS

EXAMINATION

Select the appropriate examination you took / passed for original licensure. If you took the CNAT or CRNE, it must have been the English version to be accepted. If you took a State Constructed Examination only, you are not eligible for licensure by endorsement in the State of Indiana.

☐ NCLEX-RN ☐ SBTPE-RN ☐ NCLEX-PN ☐ SBTPE-PN ☐ CNAT / CRNE ☐ CGFNS
☐ I am applying by examination and have not passed any of the examinations listed.

State administering the examination	Date examination was/will be administered on (*month, day, year*)

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

Graduates of foreign nursing schools applying via examination 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 (*two (2) to four (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 signed, written statement, 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*)

APPLICATION FOR A TEMPORARY PERMIT

An applicant for licensure by endorsement may obtain a Temporary Permit to practice nursing in Indiana as a Registered Nurse or a Licensed Practical Nurse. This permit expires at the earlier of ninety (90) days after issuance or upon issuance of a permanent license. This application should be completed **only** if the applicant is requesting a Temporary Permit. **Please provide a copy of your current license in another state with this application.**

Name of applicant (*last, first, middle*)	List any other last names ever used

Street address (*number and street or rural route*)

City	State	ZIP code

Social Security number *	* Your Social Security number is being requested according to IC 4-1-8-1. The request is MANDATORY and this application cannot be processed without it.

This is to certify that I have a current, valid license to practice nursing as follows:

☐ Registered Nurse ☐ Licensed Practical Nurse

License number	Expiration date (*month, day, year*)	State of current licensure

I further certify that my license is in good standing. I have had no disciplinary action taken on my license and no disciplinary action is pending.

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

DECLARATION OF PRIMARY STATE OF RESIDENCY

To be considered for a Compact license, Indiana must be your primary state of residency.

I declare Indiana as my primary state of residency and I am providing an Indiana address. ☐ Yes ☐ No

If you do not have a current Indiana malling address, you must provide one of the following documents showing Indiana to be your Primary State of Residence (PSOR):

- Driver's license with home address
- Voter registration card with home address
- W2 form declaring primary state of residence
- Federal income tax return including state of residence
- Military form number 2058 citing primary state of residence

Do you hold an active Nurse Licensure Compact (NLC) license In another state? ☐ Yes ☐ No

Please note, a nurse may only hold one Compact license. If you currently hold a Compact license in another jurisdiction and you are not changing your primary state of residency to Indiana you should not submit this application.

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 25-1-5-8 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*)