Reset Form

# APPLICATION FOR A LIMITED LICENSE TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM FOR PODIATRIC MEDICINE

State Form 50318 (R8 / 7-16)

Approved by State Board of Accounts, 2016

**INDIANA BOARD OF PODIATRIC MEDICINE**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2060
E-mail: pla3@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 845 IAC 1-6-9.*
2. *All fees are non-refundable and non-transferable.*
3. *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 | |
|---|---|
| **DATE RECEIVED (*month, day, year*)** | |
| **FEE AMOUNT RECEIVED** | |
| **RECEIPT NUMBER** | |
| **FEE INFORMATION** | |
| **LIMITED LICENSE NUMBER** | |
| **DATE ISSUED (*month, day, year*)** | |

**APPLICANT**

Attach one (1) passport-quality photograph of yourself here.

**DO NOT WRITE ABOVE THIS LINE**

## APPLICANT INFORMATION

| | | |
|---|---|---|
| Name (*last, first, middle, maiden or previous*) | | |
| Current address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Permanent address (*if different from address above*) | | |
| City | State | ZIP code |
| Social Security number * | Date of birth (*month, day, year*) | Place of birth (*city, state*) |
| E-mail address | | |
| Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No | | |

## PRE-PROFESSIONAL EDUCATION

| NAME OF SCHOOL | LOCATION | DATES ATTENDED *(month, day, year)* |
|---|---|---|
| | | |
| | | |

## DOCTOR OF PODIATRIC MEDICINE DEGREE GRANTED BY

| NAME OF SCHOOL | LOCATION | DATES ATTENDED *(month, day, year)* |
|---|---|---|
| | | |

(*Continued on the reverse side.*)

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 that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice podiatric medicine, or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No

3. 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

4. *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

5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ 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 signed (*month, day, year*) |
|---|---|
| | |

## 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 their authorized representatives in connection with processing my application for licensure.

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 such 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 Board of Podiatric Medicine 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 same.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |

**POSTGRADUATE TRAINING VERIFICATION FOR A LIMITED LICENSE TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM**

Part of State Form 50318 (R8 / 7-16)

**This form is to be completed by the Hospital / Institution Chairperson / Department Head, notarized and submitted directly to the address below:**

**INDIANA BOARD OF PODIATRIC MEDICINE**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.in.gov

This is to certify that ______________________ has been granted an appointment to serve at

______________________ in the Department of ______________________

located at (*address*) ______________________

This appointment is for the month and year beginning ____________ and ending ____________.

| Printed name of Hospital Chairman / Department Head | Title |
|---|---|
| Signature of Hospital Chairman / Department Head | Date (*month, day, year*) |
| Address (*number and street, city, state, and ZIP code*) | |
| Telephone number<br>(          ) | E-mail address |

SEAL OF NOTARY PUBLIC