



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

State Form 50318 (R10 / 1-21)

**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. 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
Fee information	Limited license number issued	Date limited license issued (month, day, year)

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION	
Name (last, first, middle, maiden or previous)	
Social Security number *	Date of birth (month, day, year)
Current address (number and street or rural route)	City, state, and ZIP code
Permanent address (if different from address above)	City, state, and ZIP code
Telephone number (daytime) ()	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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an active duty member of the military? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> 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)

EDUCATION PROGRAM OF EMPLOYMENT			
NAME OF EMPLOYER	POSITION	START DATE (month, day, year)	END DATE (month, day, year)

LICENSE INFORMATION

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

TYPE OF LICENSE	STATE	NUMBER	DATE ISSUED (month, year)	CURRENT STATUS

QUESTIONS

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 that you hold or have held?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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;	<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
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.

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 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 affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (month, day, year)
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**POSTGRADUATE TRAINING VERIFICATION FOR A LIMITED LICENSE
TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM**

Part of State Form 50318 (R10 / 1-21)

This form is to be completed by the Hospital / Institution Chairperson / Department Head 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 (<i>month, day, year</i>)
Address (<i>number and street, city, state, and ZIP code</i>)	
Telephone number ()	E-mail address