Reset Form

APPLICATION FOR CERTIFICATION AS AN ACUPUNCTURE DETOX SPECIALIST

State Form 50711 (R9 / 2-25)

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

INSTRUCTIONS:
1. *The fee for this application is $10.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 13-2-6.*
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.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY		
Application fee	Date fee paid *(month, day, year)*	Receipt number
Certificate number issued	Date certificate issued *(month, day, year)*	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION		
Name of applicant (*last, first, middle*)		
Social Security number *	Date of birth (*month, day, year*)	Gender ** ☐ Male ☐ Female
Address of applicant (*number and street or rural route*)	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.)*
☐ 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

HIGH SCHOOL DIPLOMA / GED GRANTED BY	
Name of school	
Location	Date of graduation (*month, year*)

ACUPUNCTURE TRAINING FOR DETOXIFICATION

NAME OF PROGRAM	LOCATION	NUMBER OF HOURS	DATE CERTIFIED *(month, day, year)*

OTHER EDUCATION AND TRAINING IN THE UNITED STATES

NAME OF SCHOOL	LOCATION	FROM *(month, year)*	TO *(month, year)*

LIST ALL PLACES YOU HAVE WORKED SINCE YOUR MOST RECENT DEGREE		
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	**DATE *(month, day, year)***

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS				
STATE	**TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT**	**NUMBER**	**DATE ISSUED *(month, day, year)***	**CURRENT STATUS**

SUPERVISORS			
NAME OF SUPERVISOR	**LICENSE NUMBER**	**FROM *(month, year)***	**TO *(month, year)***

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 you hold or have held in any state? ☐ Yes ☐ No

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

3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, 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

8. Have you ever been the subject of an investigation by a regulatory agency concerning a license? ☐ Yes ☐ No

9. Have you ever been terminated or disciplined by your employer while practicing as an acupuncturist or resigned in lieu of discipline? ☐ Yes ☐ No

10. Have you ever been excluded as a Medicare / Medicaid provider? ☐ Yes ☐ 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*)

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE SUPERVISOR.

SUPERVISING PHYSICIAN / ACUPUNCTURIST / PROFESSIONAL ACUPUNCTURIST

Name of supervisor (*last, first, middle*)

License number | Date license expires (*month, year*)

Residence address (*number and street, city, state, and ZIP code*)

Office address *(number and street, city, state, and ZIP code*)

Residence telephone number ( ) | Office telephone number ( )

E-mail address

MEDICAL, PROFESSIONAL / ACUPUNCTURE DEGREE

Name of school | Location | Date of graduation (*month, day, year*)

INSTRUCTIONS: Give a description of your practice, areas of specialization, and / or board certification.

JOB DESCRIPTION FOR THE ADS

INSTRUCTIONS: ON AN ATTACHED SHEET, give a description of the exact privileges and tasks the ADS shall be performing under your supervision. In addition, please give a detailed description of the process maintained for evaluation of the ADS. Please provide on letterhead and include address and telephone number.

LIMIT ON ADS SUPERVISION

As a supervising physician or professional acupuncturist or acupuncturist, I understand that I may NOT supervise any more than twenty (20) Acupuncture Detox Specialists at a time. *Please list the names and certificate numbers of the ADS you are currently supervising.*

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the Acupuncture Detox Specialists (ADS) named in this application will be under your continuous supervision in accordance with IC 25-2.5 and 844 IAC 13, and that you shall review all records of patient encounters performed by the ADS at least one time per month after the encounter and at all times retain professional and legal responsibility for the care rendered by the ADS.

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

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 supervisor | Date signed (*month, day, year*)