APPLICATION FOR A LIMITED TEMPORARY PERMIT TO PRACTICE CHIROPRACTIC

State Form 51116 (R4 / 7-16)
Approved by State Board of Accounts, 2016

INDIANA BOARD OF CHIROPRACTIC EXAMINERS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@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 846 IAC 1-4-7.*
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	
TEMPORARY PERMIT FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
PERMIT NUMBER	
PERMIT ISSUANCE DATE (*month, day, year*)	

PHOTOGRAPH

Attach one (1) passport-quality photograph taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number*
Address (*number and street or rural route, city, state, and ZIP code*)	
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)
Telephone number (*daytime*) ( )	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

CHIROPRACTIC SCHOOL OF GRADUATION

NAME OF SCHOOL	LOCATION (*city and state*)	DATE OF GRADUATION (*month, day, year*)

CHIROPRACTIC LICENSES HELD
(*List all states, including Indiana, in which you have been licensed or certified to practice chiropractic.*)

STATE	LICENSE NUMBER	DATE ISSUED (*month, day, year*)	DATE EXPIRES (*month, day, year*)

PURPOSE FOR TEMPORARY PERMIT

1. What is the purpose for applying for a temporary permit?

PURPOSE FOR TEMPORARY PERMIT *(continued)*

2. What is the activity, organization, function, and event with regard to which the chiropractic services will be provided?

3. Specify type, extent, and specialization of chiropractic services to be provided.

LOCATION OF SERVICE

Name of practice		
Address (*number and street or rural route*)		
City	State	ZIP code
Telephone number ( )	E-mail address	

DATES OF SERVICE (*A temporary permit is valid for a nonrenewable period of not more than thirty (30) days.*)

Beginning date (*month, day, year*)	Ending date (*month, day, year*)

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. Have you ever previously filed an application in the State of Indiana?	☐ Yes	☐ No
2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes	☐ No
3. Have you ever been denied a license, certificate, registration or permit to practice chiropractic or any regulated health occupation in any state (*including Indiana*) or country?	☐ 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. 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
6. 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 its authorized representatives in connection with processing my application for chiropractic temporary permit.

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 organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photostatic copy of the 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*)

VERIFICATION OF CHIROPRACTIC STATE LICENSURE FOR A LIMITED TEMPORARY PERMIT

Part of State Form 51116 (R4 / 7-16)
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*Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

INSTRUCTIONS:
1. *Please type or print.*
2. *Complete the top section.*
3. *Make copies to send to each state where you hold or have held a license.*
4. *Request the state(s) to complete and return directly to:*

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   PROFESSIONAL LICENSING AGENCY
   402 West Washington Street, Room W072
   Indianapolis, Indiana 46204

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number*
Address (*number and street or rural route*)	
City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address
License number	Date of issue (*month, day, year*)

AUTHORIZATION

I hereby authorize the State of _____ to provide the following information to the Indiana Board of Chiropractic Examiners.

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

License number	Date of issuance (*month, day, year*)	Expiration date (*month, day, year*)

Has the license been subject to disciplinary action? (*Please attach copies of any disciplinary action taken by your board.*)
☐ Yes ☐ No

LICENSED BY

☐ Examination ☐ Endorsement ☐ Other (*Please specify*) _____

☐ National Boards ☐ Part I ☐ Part II ☐ Part III ☐ Part IV ☐ Physiotherapy

State examination administered? ☐ Yes ☐ No	Date of examination (*month, day, year*)

Name	**Please Affix Board Seal**
Title	
State Board	
Date (*month, day, year*)	