Reset Form

APPLICATION FOR A LIMITED TEMPORARY PERMIT TO PRACTICE CHIROPRACTIC

State Form 51116 (R7 / 6-22)
Approved by State Board of Accounts, 2017

INDIANA BOARD OF CHIROPRACTIC EXAMINERS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
E-mail: pla5@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. *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	
TEMPORARY PERMIT FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
PERMIT NUMBER	
PERMIT INSURANCE DATE *(month, day, year)*	

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)*	Telephone number *(daytime)*
Email address	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 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

CHIROPRACTIC SCHOOL OF GRADUATION

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

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS

Verification of all licenses listed must be submitted directly from the state licensing board.

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?
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)*

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. 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,*	☐ Yes	☐ No
(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 contedere* 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 judgement against you or settled any malpractice action?	☐ 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)*