

APPLICATION FOR A LIMITED TEMPORARY PERMIT TO PRACTICE CHIROPRACTIC

State Form 51116 (R2 / 6-13) Approved by State Board of Accounts, 2013

INDIANA BOARD OF CHIROPRACTIC EXAMINERS

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
www.pla.lN.gov

*Your Social Security number is	s being requested by this s	tate agency in accordance	with IC 4-1-8-1. Discl	osure is mand	atory, and th	is record cannot	be processed without it.	
	FOR OF	FICE USE ONLY						
TEMPORARY PERMIT FE					PHOT	OGRAPH		
DATE FEE PAID (month, day, year)					Attach one (1) passport-quality photograph taken within the last eight (8) weeks.			
RECEIPT NUMBER								
PERMIT NUMBER								
PERMIT ISSUANCE DATE	E (month, day, year)							
	DO NOT WRITE ABOVE THIS LINE							
		APRIC	ANT INFORMATION	N				
Name of applicant (last, first, n	niddle, maiden)	AFFLIG	APPLICANT INFORMATION Social			ial Security number*		
Address (number and street or	rural route)			l				
City	Dity			State			ZIP code	
Date of birth (month, day, year)	Place of birth (city a	and state or country)		,				
Telephone number (daytime)			E-mail address	S				
NAME OF S	SCHOOL		SCHOOL OF GRAI CATION (city and s			DATE OF GRA	DUATION (month, day, year)	
1011112 01	3011001		or the territory and e	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		27.11.2 01. 01.0.	20/11/614 (<i>111611</i> 41) day, you <u>l</u>	
	st all states, including	Indiana, in which yοι		ed or certifi				
STATE	LICE	NSE NUMBER	DATE	ISSUED (m	ontn, day,	year) DATE E	XPIRES (month, day, year)	
			R TEMPORARY P	ERMIT				
What is the purpose for apply	ving for a temporary permit?	,						

PURPOSE FOR TEMPORARY PERMIT (continued)					
What is the activity, organization, function, and event with regard to which the chiroprac	tic services will be provided?				
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	o code	
Telephone number	E-mail address				
()					
DATES OF SERVICE (A temporary permit is valid for a	nonrenewable period o	not more th	an thirty (30) day	/s.)	
Beginning date (month, day, year)	Ending date (month, day, ye	ear)			
If your answer is "Yes" to any of the following, explain fully in a signed and not date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters fror Falsification of any of the following is grounds for permanent revocation of a li	n attorneys or insurance o	ompanies are	not accepted in I		
Have you ever previously filed an application in the State of Indiana?		☐ Yes	□ No		
Has disciplinary action ever been taken regarding any health license, cer	r 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?					
Except for minor violations of traffic laws resulting in fines, and arrests of (1) have you ever been arrested:	convictions that have bee	en expunged b	by a court,		
(2) have you ever entered into a prosecutorial diversion or deferment agr	reement regarding any offe	ense, misdem	eanor, or felony		
in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony	y in any state;			☐ Yes	☐ No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in a (5) have you ever pled nolo contendre to any offense, misdemeanor, or f					
5. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left					□ No
untreated may interfere, with your ability to practice in a competent and professional manner? 6. Have you ever had a malpractice judgment against you or settled any malpractice action?					□ No
APPLICATION AFFIRMATION					
APPLICATION I hereby swear or affirm, under the penalties of perjury, that the statements meaning the statement of the state		true, complet	e and correct.		
Signature of applicant		, , , , , , , , , , , , , , , , , , , ,	Date signed (mo	onth, day, ye	ear)
			,		-

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 (R2 / 6-13) Approved by State Board of Accounts, 2013

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402 West Washington Street, Room W072 Indianapolis, Indiana 46204 Telephone: (317) 234-2054 www.pla.IN.gov

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INSTRUCTIONS:

- 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:

INDIANA BOARD OF CHIROPRACTIC EXAMINERS

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	e the following information	n to the Indian	a 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 Yes No	1? (Please attach copies of any dis	ciplinary action taken by yo	our board.)				
	LICENS	SED BY					
Examination Endorsement	nt Other (<i>Ple</i>	ease specify)					
☐ National Boards ☐ Part I	Part II Part III	☐ Part IV		Physiotherapy			
State examination administered?	Date of examination (month, day, year)						
Name							
Title			Please Affix	c Board Seal			
State Board							
Date (month, day, year)							