Reset Form

APPLICATION FOR PROVISIONAL LICENSE

State Form 52569 (R6 / 11-20)

INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-3022
E-mail: pla10@pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 840 IAC 1-3-2.*
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
Date of issuance (*month, day, year*)	Provisional license number	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION		
Name of applicant (*last, first, middle, maiden*)	Social Security number *	Date of birth (*month, day, year*)
Address *(number and street, apartment number, city, state, and ZIP code)*		
Telephone number ( )	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

WORK EXPERIENCE

You must have at least two (2) years of administrative experience in a licensed health facility to qualify for a provisional license [840 IAC 1-1-14 (a)]. Please attach a complete resume documenting your administrative experience. Include your employer, position, type of business, period of time worked, duties, type of facility (SNF, ICF, etc.) and number of beds in the facility. The provisional license can only be used in the licensed health facility that is specified on page three (3) of this application.

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of a 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? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a health facility administrator or any regulated health occupation in any state (including Indiana) or country? ☐ Yes ☐ 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? ☐ 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 subject to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a health facility administrator or as another healthcare professional? ☐ 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*)

APPLICATION FOR PROVISIONAL LICENSE

Part of State Form 52569 (R6 / 11-20)

THE FOLLOWING MUST BE COMPLETED BY THE HEALTH FACILITY OWNER OR AN OFFICER OF THE FACILITY'S BOARD OF DIRECTORS.

This is a request for a provisional license as set out in IC 25-19-1-3 (b), which states:

(b) The board may issue a provisional license for a single period not to exceed six (6) months for the purpose of enabling a qualified individual to fill a health facility administrator position that has been unexpectedly vacated. Before an individual is issued a provisional license, the individual must fulfill the requirements in subdivision (a) (1) in addition to complying with other standards and rules established by the board.

Please attach a *detailed* explanation of the reason(s) the provisional license is being requested. This information *must* be included with the application for the Board to consider your request.

Name of prospective individual (*last, first, middle*)		
Name of health facility		
Address of facility (*number and street or rural route*)		
City	State	ZIP code
Telephone number of facility ( )	Number of beds in facility	
Type or level of care provided		

VERIFICATION		
I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.		
Signature of owner or officer	Title	Date (*month, day, year*)