



APPLICATION FOR PROVISIONAL LICENSE

State Form 52569 (R5 / 3-18)

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 *
Address (number and street, apartment number, city, state, and ZIP code)	
Date of birth (month, day, year)	Place of birth (city and state or country)
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 one of the following.)	
<input type="checkbox"/> I am a United States Citizen. <input type="checkbox"/> I am a qualified alien (as defined under 8 U.S.C. § 1641).	
Are you the spouse of a member of the military who is assigned to a duty station in Indiana? (Optional)	
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	<input type="checkbox"/> Yes <input type="checkbox"/> No
(5) have you ever pled <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (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 the processing of my application for a health facility administrators provisional license.

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 persons, firms, officers, corporations, associations, organizations and institutions, any information which is material to my application, and I hereby specifically release the Agency, and the Board, 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 hereby swear and affirm that I have read the above statements and agree to the same.

Signature of applicant	Date signed (<i>month, day, year</i>)
------------------------	---

APPLICATION FOR PROVISIONAL LICENSE

Part of State Form 52569 (R5 / 3-18)

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 (<i>last, first, middle</i>)		
Name of health facility		
Address of facility (<i>number and street or rural route</i>)		
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 (<i>month, day, year</i>)
-------------------------------	-------	----------------------------------