Reset Form

APPLICATION FOR SPONSORSHIP AS A CONTINUING EDUCATION PROVIDER FOR HEALTH FACILITY ADMINISTRATORS

State Form 52568 (R / 2-14)
Approved by State Board of Accounts, 2006

RETURN THIS APPLICATION TO:
INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
www.pla.IN.gov
E-mail: pla4@pla.IN.gov

FOR OFFICE USE ONLY			
Date reviewed (*month, day, year*)	Decision	Sponsor identification number	Initials
Fee amount	Date fee paid (*month, day, year*)	Receipt number	

PLEASE TYPE OR PRINT LEGIBLY

Name of sponsoring organization		
Address (*number and street, city, state, and ZIP code*)		
Daytime telephone number ( )	E-mail address	Web address

SIGNATURE OF AUTHORIZED INDIVIDUAL		
Printed name of authorized individual	Signature of authorized individual	
Title		Date signed *(month, day, year)*
Telephone number ( )	E-mail address	Fax number ( )

Our organization agrees to periodic state monitoring of our programs at the discretion of the Indiana State Board of Health Facility Administrators. ☐ Agree ☐ Do not agree

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 or Indiana State Board of Health Facility Administrators, any files, documents, records or other information pertaining to the undersigned requested by the Agency or the Board or any of their authorized representatives in connection with processing this application for approval of an organization to provide continuing education courses.

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, or the Indiana State Board of Health Facility Administrators 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 or affirm, that I have read the above statements and agree to same.

Printed name of authorized individual	Signature of authorized individual	
Title		Date signed (*month, day, year*)

NOTICE

In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or your application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become public record.