Reset Form

APPLICATION FOR REPEAT EXAMINATION FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST'S ASSISTANTS

State Form 52563 (R4 / 9-17)
Approved by State Board of Accounts, 2017

PHYSICAL THERAPY COMMITTEE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204-2724
Telephone: (317) 234-8800
E-mail: pla14@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 844 IAC 6-2-2.*
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:	
CERTIFICATION NUMBER:	

APPLICANT
Attach one (1) passport type quality photograph of yourself taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE

Please check one: ☐ Physical Therapy ☐ Physical Therapist Assistant

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number*

Date of birth (*month, day, year*)	Place of birth (*city, state or foreign country*)

Address (*number and street or rural route, city, state, and ZIP code*)

Telephone number (*daytime*)	E-mail address (*required*)
( )	

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).

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)*	Are you an active duty member of the military? *(Optional)*
☐ Yes ☐ No	☐ Yes ☐ No

Name of school	Date of graduation (*month, day, year*)

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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. 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 licensure, registration or certification 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 subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

If you answered "Yes" on your original application and submitted documentation, please check here: ☐
You only need to submit additional information if circumstances have changed since you last submitted an explanation regarding these questions.

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 or the Physical Therapy Committee any files, documents, records or other information pertaining to the undersigned requested by the Agency or Committee, or any of its authorized representatives in connection with processing my application for physical therapy or physical therapist's assistant 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 such information.

I further authorize the Professional Licensing Agency and the Physical Therapy Committee 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 the Committee 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.

Signature of applicant	Date (*month, day, year*)