Reset Form

APPLICATION FOR A NON-RENEWABLE LIMITED SCOPE TEMPORARY PSYCHOLOGY PERMIT

State Form 53738 (R2 / 2-14)
Approved by State Board of Accounts, 2010

STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-3009
E-mail: pla9@pla.IN.gov
www.pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY	
PERMIT FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
PERMIT NUMBER	
PERMIT ISSUANCE DATE (*month, day, year*)	

APPLICANT

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

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION		
Name of applicant (*last, first, middle*)		Social Security number *
Address *(number and street or rural route number)*		
City, state, and ZIP code		
Date of birth *(month, day, year)*	Telephone number (*daytime*) ( )	E-mail address (*required*)

SPECIFICATION AND IDENTIFICATION		
Specify reasons for seeking this permit		
Specify type, extent , and specialized psychological services to be provided		
Specify anticipated location and dates that the above services will be provided.		
Location		
Office address (*number and street or rural route,city, state, and ZIP code*)		
From (*month, day, year*)	To (*month, day, year*)	Telephone number ( )

DOCTORAL DEGREE GRANTED BY	
Name of school	Date of graduation (*month, day, year*)

LIST ALL STATES WHERE YOU HOLD, OR HAVE HELD A LICENSE TO PRACTICE PSYCHOLOGY		
STATE	**LICENSE NUMBER**	**STATUS**

If your answer is "Yes" to any of following, explain fully in a sworn affidavit, including all related details. Include the violation, location, date and disposition. If malpractice, provide name of plaintiff, case information, detailed description of case / events and settlement amounts, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of a statement. Falsification of any of the following is ground 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 any regulated health occupation in any state *(including Indiana)* or country, or surrendered your license?	☐ Yes ☐ No
3. Are you now, or have you ever been treated for drug or alcohol abuse?	☐ Yes ☐ No
4. Have you ever been arrested, convicted of, pled guilty or *nolo contendere* to, or are charges pending: A. A violation of any Federal, State of Local law related to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. To any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines.)*	 ☐ Yes ☐ No ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health 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
8. Have you ever been the subject of an investigation by a regulatory agency concerning a license?	☐ Yes ☐ 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 processing my application for a non-renewable limited scope temporary psychology permit.

I hereby release the aforementioned persons, firms, officers, corporations, association, organization, 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 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.

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