



APPLICATION FOR A NON-RENEWABLE LIMITED SCOPE TEMPORARY MEDICAL PERMIT

State Form 26138 (R12 / 8-17)

Approved by State Board of Accounts, 2017

**MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY**
 402 West Washington Street, Room W072
 Indianapolis, Indiana 46204
 Telephone: (317) 234-2060
 E-mail: pla3@pla.IN.gov
www.pla.IN.gov

- INSTRUCTIONS:**
1. The fee for this application is \$100.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 4-2-2.
 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.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

The non-renewable, limited scope, temporary medical permit shall be limited to a specific activity, function, series of events or purpose, and to a specific geographic area within the state, which limitations shall be stated on the face of the permit.

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 (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle)		Check one: <input type="checkbox"/> MD <input type="checkbox"/> DO		Social Security number *	
Address (number and street or rural route number, city, state, and ZIP code)					
Telephone number (daytime) ()	Date of birth (month, day, year)	Ethnicity **	Race **	Gender ** <input type="checkbox"/> Male <input type="checkbox"/> Female	
E-mail address			National Provider Identifier number		
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					

SPECIFICATION AND IDENTIFICATION

Specify reasons for seeking this permit.

Specify type, extent, and specialization medical services to be provided.

Specify exact location and dates that the above services will be provided.

Name of facility	From (month, day, year)	To (month, day, year)
Address (number and street or rural route number, city, state, and ZIP code)		Facility telephone number (daytime) ()

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY*A foreign medical school must meet LCME standards at the time of graduation.*

Name of school	Date of graduation (month, day, year)
List all states where you hold, or have held a license to practice medicine	

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country, or surrendered your license?	<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 medicine 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 facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been the subject of an investigation by a regulatory agency concerning a license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been excluded from being a Medicare or Medicaid provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?	<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)
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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 medical 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)
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