



# APPLICATION FOR ATHLETIC TRAINERS LICENSE

State Form 46715 (R9 / 4-11)

Approved by State Board of Accounts, 2011

**INDIANA ATHLETIC TRAINERS BOARD  
PROFESSIONAL LICENSING AGENCY**  
 402 West Washington Street, Room W072  
 Indianapolis, IN 46204  
 Telephone: (317) 234-2064  
 E-mail: pla5@pla.IN.gov

\* Your Social Security number is being requested by this state agency in accordance with IC 25-1-5-11. Disclosure is mandatory and this record cannot be processed without it.

<b>APPLICATION FEE</b>	
<b>DATE FEE PAID (month, day, year)</b>	
<b>RECEIPT NUMBER</b>	
<b>LICENSE NUMBER</b>	
<b>LICENSE ISSUANCE DATE (month, day, year)</b>	

**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 ( <i>last, first, middle, maiden</i> )		Social Security number *
Address ( <i>number and street or rural route number</i> )		
City, state, and ZIP code		E-mail address
Telephone number ( <i>daytime</i> ) (      )	Date of birth ( <i>month, day, year</i> )	Place of birth
Applying for licensure by: <input type="checkbox"/> Endorsement from another state <input type="checkbox"/> Examination		
Are you an Indiana resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you performing athletic training in Indiana more than 180 days per year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you desire a temporary permit? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### ATHLETIC TRAINER EDUCATION

Pursuant to Indiana Code 25-5.1-3-1, applicants for licensure as an athletic trainer in the State of Indiana must show completion of the following accredited courses. Please indicate the institution at which you have completed the required courses. **Applicants using CAAHEP / CAATE accredited curriculums and applicants using a BOC internship must complete the course information on this form.** Applicants must also provide an official transcript from each institution at which courses were completed or clinical experience was acquired.

Did you complete a CAAHEP / CAATE approved curriculum? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of institution
Type of degree received	
Located at ( <i>city, state</i> )	Dates attended: ( <i>month, year</i> ) From                      To
<i>Provide the total number of hours of athletic training experience you have completed under the supervision of a BOC certified athletic trainer while completing the requirements for this degree:</i>	
Did you complete a BOC internship? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of institution
Type of degree received	
Located at ( <i>city, state</i> )	Dates attended: ( <i>month, year</i> ) From                      To
<i>Provide the total number of hours of athletic training experience you have completed under the supervision of a BOC certified athletic trainer while completing this internship:</i>	
These hours were completed: ( <i>month, year</i> ) From                      To	
Human anatomy was completed at:	
Course title	Course number

**ATHLETIC TRAINER EDUCATION (continued)**

Human physiology was completed at	
Course title	Course number
Physiology of exercise was completed at	
Course title	Course number
Kinesiology was completed at	
Course title	Course number
Personal health was completed at	
Course title	Course number
Basic athletic training was completed at	
Course title	Course number
Advanced athletic training was completed at	
Course title	Course number
Therapeutic modalities was completed at	
Course title	Course number
Rehabilitation was completed at	
Course title	Course number

**OTHER EDUCATION AND TRAINING**

INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE <i>(month, day, year)</i>	TO DATE <i>(month, day, year)</i>	TYPE OF DEGREE RECEIVED

**BOC CERTIFICATION**

Date of certification <i>(month, day, year)</i>	Certification number	Date of expiration <i>(month, day, year)</i>	Is your certification current? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	----------------------	--	--

*List all places of athletic training related employment since graduation, including self-employment.*

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	HRS / WK	DATES <i>(month, day, year)</i>

Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation?  Yes  No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

TYPE OF LICENSE	STATE	NUMBER	DATE ISSUED (month, day, year)	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including location, date and disposition. If malpractice, provide name of plaintiff. 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?  Yes  No
2. Have you ever been denied a license, certificate, registration or permit to practice athletic training or any regulated health occupation in any state (including Indiana) or country?  Yes  No
3. Are you now, or have you ever been treated for drug or alcohol abuse?  Yes  No
4. Have you ever been convicted of, pled guilty or *nolo contendere* to:
  - A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?  Yes  No
  - B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines)  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 restriction, probation or other type of discipline or limitations?  Yes  No
6. Have you ever been admonished, censured, 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

**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 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 athletic trainer certification.

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 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)
------------------------	-------------------------

**VERIFICATION OF BOC EXAMINATION / CERTIFICATION STATUS**

**TOP PORTION COMPLETED BY APPLICANT**

Name of applicant (*last, first, middle, maiden or previous*)

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

Social Security number or identification number

E-mail address

BOC number

I hereby give my permission to the BOC to release my examination results and certification status to the Indiana Athletic Trainers Board for the purpose of documenting my qualification for licensure as an athletic trainer in Indiana.

Signature of applicant

Date (*month, day, year*)

An appropriate official of the BOC must complete the remainder of this verification form. Please ask the BOC to return this form directly to the Indiana Athletic Trainers Board. Mail this form along with a check or money order in the amount of twenty-five dollars (\$25.00), made payable to BOC to the following address:

NATA Board Of Certification, Inc.  
ATTN: Certification Verification Department  
1415 Harney Street, Suite 200  
Omaha, NE 68102

I hereby certify that the following person took and achieved the minimum passing score on the BOC Examination. (*If applicant has not been certified, please note same.*)

Name of applicant

Date of certification (*month, day, year*)

Certification number

Applicant is in good standing?

Yes  No

SEAL

Signature of BOC official

Printed name

Title

Date (*month, day, year*)

RETURN COMPLETED FORM TO:  
INDIANA ATHLETIC TRAINERS BOARD  
PROFESSIONAL LICENSING AGENCY  
402 WEST WASHINGTON STREET, ROOM W072  
INDIANAPOLIS, IN 46204

## VERIFICATION OF SUPERVISION

Applicants applying for a temporary permit, who have not taken the BOC examination, must practice under the supervision of an athletic trainer who is licensed by the State of Indiana during the ninety (90) days in which the temporary permit is valid.

Applicants must forward this form to the licensed athletic trainer who will be supervising the applicant. The form must be completed, notarized and submitted to the Professional Licensing Agency by the qualified supervisor.

This is to verify that \_\_\_\_\_ will be under my supervision while practicing athletic training. According to Indiana Code 25-5.1-3-8 (b), 898 IAC 1-1-9 and 898 IAC 1-4-1, I understand that I shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed. I understand that the patients care shall always be my responsibility. I also understand that it is my responsibility to maintain records of experiential hours for the person being supervised.

Beginning date ( <i>month, day, year</i> )	Signature of supervisor
Name of setting where supervision will occur	Printed name of supervisor
Address of setting where supervision will occur	Indiana license number of the supervisor
<b>SEAL OF NOTARY PUBLIC</b>	Date ( <i>month, day, year</i> )
	Telephone number (        )
	<b>MAIL COMPLETED FORM TO:</b> <b>INDIANA ATHLETIC TRAINERS BOARD</b> <b>PROFESSIONAL LICENSING AGENCY</b> <b>402 WEST WASHINGTON STREET, ROOM W072</b> <b>INDIANAPOLIS, IN 46204</b>

**TEMPORARY PERMITS ARE NOT AVAILABLE ON A WALK-IN BASIS.**

NOTE: According to IC 25-5.1-3-8, a temporary permit expires the earlier of: (1) the date the person holding the permit is issued a license; (2) the date the Board disapproves the person's application of licensure; or (3) ninety (90) days after the date of issuance of the temporary permit.

**VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR ATHLETIC TRAINING LICENSURE APPLICANTS**

**APPLICANT:** Complete the top section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.

Name of applicant ( <i>last, first, middle, maiden or given surname</i> )		
Address ( <i>number and street or rural route, city, state, and ZIP code</i> )		
Social Security number *	Date of birth ( <i>month, day, year</i> )	Telephone number ( <i>daytime</i> ) (       )
I hereby authorize, _____, to furnish the Professional Licensing Agency with the information below.		
Signature of applicant		Date ( <i>month, day, year</i> )

The remainder of this form must be completed, notarized and submitted by the employer. Please mail completed form to: Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Name of employer
Name of business / institution where employed
Address of business / institution ( <i>number and street, city, state, and ZIP code</i> )

Telephone number of business / institution (       )	Date employment began ( <i>month, day, year</i> )	Date employment ended ( <i>month, day, year</i> ) <i>(If currently employed, please indicate)</i>
Number of hours applicant worked per week	Position held	E-mail address

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience. I do hereby declare that the information contained herein is true and correct.

SEAL OF NOTARY PUBLIC	Signature
	Printed name
	Title
	Date ( <i>month, day, year</i> )

**ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.**