PART II.
APPLICATION FOR A STUDENT PERMIT TO PRACTICE RESPIRATORY CARE
HOSPITAL OR FACILITY OF EMPLOYMENT

Part of State Form 50819 (R9 / 8-24)

(*This form is to be completed by the hospital or facility where the applicant will be employed.*)

NAME OF STUDENT	
Name of student	Social Security number *

NAME OF LICENSED RESPIRATORY CARE PRACTITIONER SUPERVISOR DESIGNEE	
Name of RCP supervisor designee	
Respiratory care license number	Expiration date (*month, day, year*)
Telephone number ( )	E-mail address

HOSPITAL OR FACILITY OF EMPLOYMENT		
Name of hospital or facility		
Address (*number and street or rural route*)		
City	State	ZIP code

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 licensed respiratory care practitioner	Date signed (*month, day, year*)

SUPERVISION OF STUDENT PERMIT HOLDER

ACCORDING TO IC 25-34.5-2-14(f) & (g):

(f) A holder of a student permit shall meet in person at least one (1) time each working day with the permit holder's supervising practitioner or a designated respiratory care practitioner to review the permit holder's clinical activities. The supervising practitioner or a designated respiratory care practitioner shall review and countersign the entries that the permit holder makes in a patient's medical record not more than seven (7) calendar days after the permit holder makes the entries.

(g) A supervising practitioner may not supervise at one (1) time more than three (3) holders of student permits issued under this section.

IF THE STUDENT PERMIT HOLDER LEAVES YOUR EMPLOYMENT YOU MUST NOTIFY THE RESPIRATORY CARE COMMITTEE.

Please return this application to the following address:

Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

Telephone: (317) 234-8800
E-mail: pla14@pla.IN.gov