APPLICATION FOR A TEMPORARY MEDICAL PERMIT
(For Postgraduate Training or Teaching)

State Form 17598 (R6 / 9-96)

Approved by State Board of Accounts 1996

Health Professions Bureau
402 W. Washington St., Rm. 041
Indianapolis, IN 46204
Telephone: (317) 232-2960

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.

REQUIREMENTS AND INSTRUCTIONS TO THE APPLICANT

A. Mail completed application, along with items listed below, to the Health Professions Bureau.

1. ***FEE:*** *Submit the ten dollar ($10) fee made payable to the Health Professions Bureau. Fees are non-refundable and non-transferable.*
2. ***PROOF OF GRADUATION:*** *You must submit proof of graduation by submitting one of the following documents:*

   (a) ***CERTIFICATE OF COMPLETION*** *An original letter from the Dean of your medical / osteopathic school, stating that you have completed (not expected to) all requirements for graduation and the date when the degree will be or was awarded.*

   (b) ***OFFICIAL TRANSCRIPT*** *An* ***official*** *transcript of grades from the medical / osteopathic school, showing degree has been conferred. Graduates of foreign medical schools must submit notarized copies of all subjects and grades (mark sheets). Include official translation if not in english. (SEE NOTARIZED COPY NOTE)*

   (c) ***DEGREE*** *A notarized copy of your medical / osteopathic degree. Include official translation if not in english. (SEE NOTARIZED COPY NOTE)*

3. ***PHOTOGRAPH*** *Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.*
4. ***HOSPITAL / INSTITUTION CERTIFICATION*** *The Hospital / Institution Certification must be completed by the Hospital / Insitution Chairman Department Head.*

PERMITS ARE NOT AVAILABLE ON A WALK-IN BASIS FROM THE BUREAU. NO EXCEPTIONS.

NOTE: If you change postgraduate programs and wish to renew your temporary permit you must file a new application.

NOTARIZED COPY NOTE: Any notarized copy of an original document must have the notary public make a statement to the fact that the notary has seen the original document.

The Temporary Medical Permit application and requirements MUST be filed with the Health Professions Bureau at least ten (10) days BEFORE THE RESIDENCE/TEACHING IS SCHEDULED TO BEGIN. It is a violation in the State of Indiana to practice without a valid permit or license.

IT IS YOUR RESPONSIBILITY TO NOTIFY THE BUREAU OF YOUR PERMANENT ADDRESS ONCE IT IS ESTABLISHED.

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.

APPLICANT INFORMATION

Name of applicant *(last, first, middle)*	Social Security number
Address *(number and street or Rural Route number)*	
City, state, ZIP code	

Telephone number *(daytime)*	Date of birth *(month, day, year)*	Place of birth
Please indicate what address you want your permit sent to *(number and street)*		
City, State, ZIP code		

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY:

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

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 Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned, requested by the Bureau or any of its authorized representatives in connection with processing my application for a 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 Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau 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.

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

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY MEDICAL PERMIT OR A TEMPORARY MEDICAL TEACHING PERMIT

(to be completed by the hospital / institution Chairman / Department Head)

This is to certify that _____ has been granted

an appointment to serve at _____ in

the Department of _____

located at *(address)* _____

this appointment is for the month and year beginning _____ and ending _____

Name of Hospital Chairman/Department Head	Title	
Signature	Date of signature *(month, day, year)*	Telephone number ( )