



APPLICATION FOR REGISTRATION UNDER THE PROFESSIONAL CORPORATION ACT

State Form 50160 (R3 / 3-12)

Approved by State Board of Accounts, 2012

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
Fax: (317) 233-4236
www.pla.IN.gov

INSTRUCTIONS: Please type or print.

FOR OFFICIAL USE ONLY			
Application fee	Date fee paid (month, day, year)	Receipt number	Registration number

DO NOT WRITE ABOVE THIS LINE

Name of corporation		
Principal office address (number and street or rural route, city, state, and ZIP code)		

Telephone number (daytime) ()	E-mail address	Website address

Check one corporation type:

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Environmental Health	<input type="checkbox"/> Nursing	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Multidisciplinary
<input type="checkbox"/> Athletic Training	<input type="checkbox"/> Health Facility Administration	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Podiatry	
<input type="checkbox"/> Audiology	<input type="checkbox"/> Hearing Aid Dealer	<input type="checkbox"/> Occupational Therapy Assistant	<input type="checkbox"/> Psychology	
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Hypnotism	<input type="checkbox"/> Optometry	<input type="checkbox"/> Respiratory Care	
<input type="checkbox"/> Dental	<input type="checkbox"/> Marriage and Family Therapy	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Social Work	
<input type="checkbox"/> Dental Hygiene	<input type="checkbox"/> Medical	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech-Language Pathology	
<input type="checkbox"/> Dietetics	<input type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Physical Therapy Assistant	<input type="checkbox"/> Veterinary	

NOTE: Complete and return this application with the fee payable to the Professional Licensing Agency. A certificate of registration will be issued from this office which you must file with the Office of the Secretary of State of Indiana, State House, Indianapolis, Indiana. **THIS APPLICATION DOES NOT CONSTITUTE A CERTIFICATE AND CANNOT BE USED FOR FILING WITH THE INDIANA SECRETARY OF STATE.**

PLEASE NOTE: THE REGISTRATION PROCESS WILL NOT BE COMPLETE UNTIL THE PROFESSIONAL LICENSING AGENCY RECEIVES A COPY OF THE ARTICLES OF INCORPORATION CERTIFIED BY THE OFFICE OF THE SECRETARY OF STATE. We suggest that you submit an extra copy of the Articles of Incorporation to the Office of the Secretary of State for this purpose.

Notification shall be given to the Professional Licensing Agency within thirty (30) days after a change of business address of the Corporation and the admission or withdrawal of a shareholder. Notification shall include the names and addresses of both the transferrer and transferee shareholders. In addition, a certified copy of all amendments to the Articles of Incorporation must be submitted to the Professional Licensing Agency.

List name, address, and licensure data for each shareholder, officer and director of the proposed corporation. Check the appropriate box in the last column. Attach additional 8-1/2" x 11" sheet if necessary.

NAME AND ADDRESS	PROFESSION	INDIANA LICENSE NUMBER	OTHER STATE LICENSE (State and License Number)	STATUS
				<input type="checkbox"/> Shareholder <input type="checkbox"/> Officer <input type="checkbox"/> Director
				<input type="checkbox"/> Shareholder <input type="checkbox"/> Officer <input type="checkbox"/> Director
				<input type="checkbox"/> Shareholder <input type="checkbox"/> Officer <input type="checkbox"/> Director
				<input type="checkbox"/> Shareholder <input type="checkbox"/> Officer <input type="checkbox"/> Director
				<input type="checkbox"/> Shareholder <input type="checkbox"/> Officer <input type="checkbox"/> Director

(Continued on the reverse side)

NAME AND ADDRESS	PROFESSION	INDIANA LICENSE NUMBER	OTHER STATE LICENSE (State and License Number)	STATUS
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The undersigned hereby make(s) application for a certificate to establish and operate a professional corporation. This application is to show that each proposed shareholder and director of the corporation is a reputable and responsible health care professional as required by IC 23-1.5-1-8 and IC 23-1.5-2-3. The corporation further agrees to comply with IC 23-1.5, and agrees that the corporation will be organized in compliance with the statutes and regulations of the relevant licensing authorities. I / We hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete, and correct. If this application is signed by an incorporator who is not a shareholder, the incorporator further certifies that the incorporator has been duly granted the authority by the shareholders and directors of the proposed corporation to sign this application.

Signature of applicant	Signature of applicant
Printed name of applicant	Printed name of applicant
<input type="checkbox"/> Incorporator <input type="checkbox"/> Shareholder	<input type="checkbox"/> Incorporator <input type="checkbox"/> Shareholder
Date signed (month, day, year)	Date signed (month, day, year)
Signature of applicant	Signature of applicant
Printed name of applicant	Printed name of applicant
<input type="checkbox"/> Incorporator <input type="checkbox"/> Shareholder	<input type="checkbox"/> Incorporator <input type="checkbox"/> Shareholder
Date signed (month, day, year)	Date signed (month, day, year)

**VERIFICATION OF STATE LICENSURE FOR
INDIANA PROFESSIONAL CORPORATION
REGISTRATION APPLICATION**

Part of State Form 50160 (R3 / 4-11)

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You do not need to complete this form if you are licensed to practice in Indiana.

Privacy Notice: This state agency is requesting disclosure of your Social Security number, in accordance with Indiana Code. This form cannot be processed without it.

INSTRUCTIONS FOR PRACTITIONERS: Please type or print. Complete the top section. Make copies and send to each state in which you hold a license. Have the state(s) send this form directly to the Professional Licensing Agency. This form is to be used only for verification of licensure status for the purpose of registering a professional corporation. It cannot be used for applying for verification when applying for a license. The Professional Licensing Agency will accept the standard state verification form provided by another state in lieu of this form.

Name (<i>last, first, middle</i>)		
Type of health profession license held		
Social Security number		
License number	Date of issuance (<i>month, day, year</i>)	Date of birth (<i>month, day, year</i>)
I hereby authorize the State of _____, to furnish to the Professional Licensing Agency the information below.		
Signature of practitioner		

PRACTITIONER: DO NOT WRITE BELOW THIS LINE.

License number	Date of issuance (<i>month, day, year</i>)	Profession
License is current and in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date (<i>month, day, year</i>)	Any derogatory information? <input type="checkbox"/> Yes <input type="checkbox"/> No
IF LICENSE HAS BEEN ENCUMBERED IN ANY WAY, PLEASE PROVIDE CERTIFIED COPIES OF ALL RELATED DOCUMENTS. PLEASE AFFIX BOARD SEAL. Form completed by:		
Name (<i>please print</i>)	Title	
Signature	Date (<i>month, day, year</i>)	
Name of State Board		