Reset Form

TELEHEALTH PROVIDER'S EMPLOYER OR CONTRACTOR CERTIFICATION

State Form 56085 (R6 / 5-21)

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

INSTRUCTIONS: This Telehealth Provider's Employer or Contractor Certification ("Certification") is required by Indiana Code §25-1-9.5.

This Certification must be completed and filed with the Indiana Professional Licensing Agency before the employee provider or contract provider may establish a provider-patient relationship or issue a prescription under IC §25-1-9.5-8 for an individual located in Indiana.

EMPLOYER OR CONTRACTOR INFORMATION

Name of entity employing or contracting with provider	Does this entity employ or contract with providers? ☐ Yes ☐ No
Name of provider employee or provider contractor	License number

The provider is:

- ☐ A physician licensed under IC 25-22.5
- ☐ A physician assistant licensed under IC 25-27.5
- ☐ An advanced practice registered nurse licensed and granted authority to prescribe drugs under IC 25-23
- ☐ An optometrist licensed under IC 25-24
- ☐ A podiatrist licensed under IC 25-29
- ☐ Athletic trainer licensed under IC 25-5.1
- ☐ Chiropractor licensed under IC 25-10
- ☐ Dental Hygienist licensed under IC 25-13
- ☐ Dentist licensed under 25-14
- ☐ Individual holding a dental residency permit under IC 25-14-1-5
- ☐ Individual holding a dental faculty license under IC 25-14-1-5.5
- ☐ Diabetes educator licensed under IC 25-14.3
- ☐ Dietitian licensed under IC 25-14.5
- ☐ Genetic counselor licensed under IC 25-17.3
- ☐ Individual holding a temporary physician permit under IC 25-22.5-5-4
- ☐ Nurse licensed under 25-23
- ☐ Behavior health and human services professional licensed under IC 25-23.6
- ☐ Optometrist licensed under IC 24
- ☐ Pharmacist licensed under IC 25-26
- ☐ Physical therapist licensed under IC 25-27
- ☐ Psychologist licensed under IC 25-29
- ☐ Respiratory care practitioner licensed under IC 25-34.5
- ☐ Speech-language pathologist or audiologist licensed under IC 25-35.6
- ☐ Veterinarian licensed under IC 25-38.1
- ☐ Out of state provider with a license type listed above

Employee identification number of entity	Telephone number of entity ( )	E-mail address of entity

AUTHORIZED REPRESENTATIVE INFORMATION

Name of entity's duly authorized representative with authority to execute this Certification	Title of representative
Address *(number and street, city, state, and ZIP code)*	
Telephone number of representative ( )	E-mail address of representative

CERTIFICATION

Employer or contractor agrees to be subject to the jurisdiction of the courts of law of Indiana and Indiana substantive and procedural laws concerning any claim asserted against the provider arising from the provision of health care services under IC §25-1-9.5 to an individual who is located in Indiana at the time the health care services were provided.

The filing of this Certification constitutes a voluntary waiver by the employer or contractor of any respective right to avail themselves of the jurisdiction or laws other than those specified in IC 25-1-9.5-9(b) concerning the claim.

I swear or affirm under the penalties of perjury that the foregoing representations are true.

Signature	Date signed *(month, day, year)*
Printed name	