# Indiana University South Bend
# Division of Nursing and Health Professions
# Health Care Provider Affidavit Form

Applicant Name: ________________________________ Date:_________

Please read and sign this portion of the form ***only if you can attest, to the best of your knowledge at this time, that the below statement is true.***

I attest, to the best of my knowledge, that I have no current or past actions resolved or pending that have had or would have had an impact upon my licensure as a Health Care Provider in any state or country in which that I have been licensed to practice.

_____________________________________ ____________________
Legal Signature Date

***If you are unable to sign the above statement*** due to any current, resolved or unresolved past action(s) that have or may have impacted upon your licensure as a Health Care Provider in any state or country in which that you have been licensed to practice, please sign below:

_____________________________________ ____________________
Legal Signature Date