INDIANA **Last Reviewed and/or Updated 06/30/2023 Cheryl Richard**	**DISCLAIMER: The information contained in this publication is intended for informational purposes only, and is not an attempt to direct workers' compensation claimants to use any particular care provider (whether listed herein, or not). FCCI Services, Inc. and its affiliated entities, their respective officers, directors, employees, attorneys and agents (collectively, "FCCI") shall not be liable for any loss, injury, death, damage, liability, claim or expense whatsoever arising out of the use of, or reliance upon, the information contained in this publication. Any information contained herein is provided as a courtesy, and is not intended to be relied upon as legal or professional advice. FCCI makes no representations or warranty, either express or implied, as to the accuracy or completeness of the information contained herein, or as to whether or not any particular use of the information referenced in this publication is permitted by law. You are encouraged to consult with your own legal counsel to ensure your compliance with the law.**
Work Comp State Website Information	http://www.in.gov/wcb/; https://secure.in.gov/wcb/2329.htm; https://iga.in.gov/laws/2019/ic/titles/22#22-3; FAQ's - https://faqs.in.gov/hc/en-us/sections/115001504688-Worker-s-Compensations-Board-of-Indiana; https://www.in.gov/wcb/insurance-carriers/nurse-case-manager-guidelines/
Medical Provider Selection	**IC 22-3-3-4(b)(c):** Employer/Carrier directs the care and can get 2nd opinions and change physicians. "The employer (carrier) shall furnish or cause to be furnished, free of charge to the employee, an attending physician for the treatment of the employee's injuries, and in addition thereto such services and products as the attending physician or the Worker's compensation board may deem necessary. "If the injured worker wants a 2nd opinion, it is done so at the injured worker's expense.
IME or Similar	**IC 22-3-3-6(a)(b)(c)(d)**: Injured worker is not entitled to a 2nd opinion but he/she is entitled to an IME when he/she receives form 38911 (Request of claim status/request for IME) advising him/her of benefit termination. Injured worked must complete the bottom of form 38911 and return it to the Indiana Workers Comp Board within 7 days after receipt of the form. The Board selects the IME physician and schedules the appointment. Carrier pays for the IME and must pay sufficient money in advance to cover travel expenses (see mileage reimbursement section below). "In all cases where an exam of an employee is made by a physician or surgeon engaged by the employee, and the employer has no physician or surgeon present at such exam, it shall be the duty of the physician or surgeon making the exam to deliver to the employer (carrier) a statement in writing of the conditions evidenced by such exam. Employer/carrier is entitled to an IME. Prepay is needed for all travel expenses to the IME, if outside of county of employment. "After an injury and during the period of claimed resulting disability or impairment, the employee, if so requested by the employer (carrier) or ordered by the WC board shall submit to an examination at reasonable times and places by a duly qualified physician or surgeon designated and paid by the employer (carrier) or by order of the WC board. The employee shall have the right to have present at any such examination any duly qualified physician or surgeon provided and paid by the employee. Any employer (carrier) requesting an exam of any employee residing within Indiana shall pay, in advance of the time fixed for the exam, sufficient money to defray the necessary expenses of travel." (see the mileage reimbursement section below). **FCCI Claims:** The IME process is an adjusting process, used strategically by the adjuster to progress the file in a pro-active manner. The adjuster (or assistant) should schedule the IME appointment and send the letter to the physician's office outlining what is to be addressed during the appointment. The telephonic case manager (TCM) can provide consultative services to assist the adjuster in the following areas: • Selecting the pertinent medical records to accompany the IME letter that the adjuster will send. • Drafting the medical portion of the IME letter to ensure that all pertinent medical issues are appropriately outlined from a medical standpoint. The adjuster will send the finalized letter to the physician, under the adjuster's name, not the TCM's name. Depending on the issues that are being addressed at the IME, the adjuster may opt to request that a field case manager (FCM) be assigned to either attend the IME appointment with the injured worker (if allowed) or to speak with the physician after the appointment. This can expedite transmission of the appointment outcome back to the adjuster. Each file scenario is different, so the adjusting staff will use the information above as a guide when approaching an IME, and make the appropriate file decisions based on the specific needs of that file.
Causal Relation	**IC 22-3-3-12**: Aggravation of a pre-existing condition arising out of and in the course of employment is compensable. "If an employee has sustained a permanent injury either in another employment, or from other cause or causes than the employment in which he received a subsequent permanent injury by accident, they shall be entitled to compensation for the subsequent permanent injury in the same amount as if the previous injury had not occurred: Provided, however, That if the permanent injury for which compensation is claimed, results only in the aggravation or increase of a previously sustained permanent injury or physical condition, regardless of the source or cause of such previously sustained injury or physical condition, the board shall determine the extent of the previously sustained permanent injury or physical condition as well as the extent of the aggravation or increase resulting from the subsequent permanent injury, and shall award compensation only for that part of such injury, or physical condition resulting from the subsequent permanent injury." Open communication is allowed with the authorized treating physicians and any questions may be asked by the MCM.
Hernia	No specific statute found
Psych	Mental stress is compensable if stress level is above normal work environment stress. Does not have to be associated with a physical injury
Chiro	Unlimited treatment but must be reasonable and necessary
Mileage Reimbursement	**IC 22-3-3-4(a):** "If the employee is requested or required by the employer (carrier) to submit to treatment outside of the county of employment, the employer (carrier) shall also pay the reasonable expense of travel, food and lodging necessary during the travel, but not to exceed the amount paid at the time of the travel by the state to its employees under the state travel policies and procedures established by the department of administration and approved by the state budget agency. If the treatment or travel to or from the place of treatment causes a loss of working time to the employee, the employer (carrier) shall reimburse the employee for the loss of wages using the basis of the employee's average daily wage."
Lifetime Prosthetics	**IC 22-3-3-4(f)**: Yes; however, the secondary fund pays for replacement prosthetics. "Regardless of when it occurs, where a compensable injury results in the amputation of a body part, the enucleation of an eye, or the loss of natural teeth, the employer shall furnish an appropriate artificial member, braces, and prosthodontics. The cost of repairs to or replacements for the artificial members, braces, or prosthodontics that result from a compensable injury pursuant to a prior award and are required due to either medical necessity or normal wear and tear, determined according to the employee's individual use, but not abuse, of the artificial member, braces or prosthodontics, shall be paid from the second injury fund upon order or award of the worker's compensation board. The employee is not required to meet any other requirement for admission to the second injury fund."

Impairment Rating Guide	**IC 22-3-3-6(e)**: State Specific Guide - Updated March 2023. Evaluation Physicians may use whichever edition of the AMA Guides to the Evaluation of Permanent Impairment they think most appropriate to the individual case when evaluating the permanent impairment of an injured worker. For example, if the 6th Edition would preclude recovery for an impairment, an earlier edition should be consulted. One such impairment would be a severe loss of grip strength experienced with amputation of multiple digits on one hand. The 5th edition takes this into account while the 6th does not. The report of the physician or surgeon, required by IC 22-3-3-10.5, must contain the elements set out in IC 22-3-3-6(e). Processing In all cases where a PPI rating has been issued (0-100%), it should be filed with the Board via paper copy. 0% PPIs, just like monetary ones, should be accompanied by the waiver and medical report and an attempt to obtain signatures should be made. If the worker refuses to sign the SF1043 and/or waiver, a copy may be filed for compliance purposes 30 days after submission to the injured worker. Do not send a copy to the Board at the time you send it to the injured worker for signature. Please include a second copy and a self-addressed stamped envelope if you would like a file-marked copy returned. None will be returned without the envelope. Only supplemental documentation requested by the Board may be sent via email to the person requesting it. Overall, the process for filing the 0% PPI is the same for both indemnity & med only claims. Ideally, the PPI rating is submitted at the time of filing of the SX (38911) through EDI. However, in most cases, the PPI rating is not going to be available at the time of SX filing and as such will either need to be filed on a SROI 02 or on the FN if the rating is a 0%. On claims with a monetary PPI, payments should be reported via SROI PY after receiving Board approval. Calculating the Value of the PPI Impairment ratings should be to the most specific body part affected. Exceptions are when multiple body parts are involved. Translating a simple finger injury to the upper extremity or the body as a whole is not necessary, as the Worker's Compensation Board per IC 22-3-3-10(f) will only approve payment for the impairment of the finger. The Board will no longer apply the Multi-Digit Calculation which is not required by current statutes. If multiple digits are impaired, but there is no amputation, a hand rating will be approved. A wrist injury will be considered an impairment of the upper extremity but if use of the hand is also affected, there should be a hand rating as well and these will be combined. If there are impairments to various parts of a limb, such as a left elbow and left wrist, the Board will approve payment for the combined rating to the left upper extremity. Upper and lower extremity impairments will no longer be separated into above or below the joint except in the case of amputations, per IC 22-3- 3-10(f)(1), (3), (8) and (9). Upper extremity ratings will be based on 50 degrees; lower extremity to 45 degrees. Ankle impairments are sometimes rated using the ankle/foot conversion table, found in the 5th and 6th editions of the AMA Guidelines. Sometimes a physician will rate to the lower extremity with an ankle injury, similar to the treatment of a wrist injury. The Board will accept both, but will not take the injury out to the whole body. Head, neck, shoulder, back, hip, hernias, and any bilateral injury are currently rated to the whole person. An exception is the shoulder injury that occurs to the “ball” and not the “socket”, which the physician will rate to the upper extremity. Additionally, if two different body parts are injured in the same accident, these are rated individually and then converted to the whole person. Amputations are the exception to this practice. Amputations are always calculated separately, per IC 22-3-3-10(f) and added to impairments to other body parts or a whole person rating. Burn and other skin impairments are written to the whole body because skin is an organ and will now also be approved for payment this way.
	Amputations Amputations require unique evaluations according to the particular case and make general rules impractical, especially where additional impairments are also involved. Please feel free to contact the Board for help with these evaluations. Amputations are never combined into whole person ratings with other injuries. Partial amputations of hands and feet require completion of the hand or foot chart delineating the exact location of the loss by separation. This must be submitted along with the PPI report. When, in addition to a loss by separation of one or more digits, use of the hand is affected and a hand rating is given by the physician, the Board will add on the value of the digit loss once instead of doubling it per IC 22-3-3-10(f)(2), because the amputation is already factored into the physician’s rating once. When the loss of grip strength and pinch ability with fingers lost raises the value of the PPI beyond a straight amputation, this must be considered. However, if this calculation results in a lower dollar PPI than a straight doubling of the lost digits, the lost digits must be paid per statute as the law must be given preference over any edition of the AMA Guidelines. Doubling refers to the dollars paid, not the degrees. See IC 22-3-3-10(f)(2). A similar practice will be followed with feet and toes but only if additional loss of use and function of the foot is reflected in the PPI provided according to the AMA Guidelines. The PPI should never be valued at less than the toes doubled per statute. When multiple digits are amputated but the physician rates no impairment/loss of use to the hand/foot, the digits will be added together and doubled but will not be combined into a hand or foot impairment. Serious consideration should be given to using the 5th edition of the AMA Guidelines with the amputation of multiple fingers because of the effect this has on the use of the hand and thus the upper extremity. The escalation clause of IC 22-3-3-10(j)(15) will apply. Contrary to the case of loss of use of multiple parts of the body, an amputation will not be combined with a loss of function impairment of a different body part into a whole person rating. The amputation will be doubled and paid in addition to the loss of use impairments and the escalation clause of IC 22-3-3-10 (j)(15) will apply. Loss of fatty tissue alone, without bone loss, does not constitute an amputation within the terms of the statute and will be paid per the physician’s rating.
State Prescription Drug Monitoring Data Base	https://www.in.gov/pla/inspect/ Statute IC 35-48-7-8.1: Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT) requires licensed dispensers throughout Indiana, and out-of-state (non-resident) pharmacies licensed to dispense drugs in Indiana, to submit schedule II, III, IV and V controlled substance prescription data to the data base every seven (7) days. Physicians & Law Enforcement agencies can access the data base. IN has the same Prescription Monitoring Program (PMP) data base monitoring system which allows the sharing of data across their state line with the following states: AZ, CN, IL, IN, KS, LA, MI, NM, ND, OH, SC, SD, & TN
Prescriptions	Not a generic mandate state, but allows for Generic substitution by the Pharmacist if "Brand only" is not indicated by the Physician. For brand name drugs, the Physician must sign the prescription signature line labeled "May not substitute' or "Dispense as Written". **Effective 1-1-19: IC 22-3-3-4.7 - IN SB 369** adopted ODG drug formulary regardless of the date of injury. Any 'N' drug not authorized by FCCI must be sent for peer review and a decision (notification) f non-certification must be sent to both the requesting physician & IW and/or attorney within five (5) business days after receiving the request. IW may apply to the WC board for a final determination regarding the peer review determination. Failure to notify the requesting physician and the IW within five (5) business days of receipt of the request, will result in an automatic approval of the drug 1. Exemption applies and allows the use of 'N' drugs during a medical emergency. 2. If the injured worker began use of the 'N' drug before July 1, 2018, and continues to use the drug after 1-1-19, reimbursement is permitted for the drug until 1-1-20. 3. If the employer/carrier denies the 'N' drug, the request must be sent to a URAC accredited third party (peer review) to make a determination. The prescribing physician and the injured worker must be notified of the determination by the third party no later than five (5) business days after receiving the request. If the employer/carrier fails to provide the notification timely, the physician's request is considered approved and reimbursement of the 'N' drug is authorized. 4. The injured worker may apply to the Workers Comp Board for a final determination if the third party issues a denial for the 'N' drug.
Special Forms or Filings	Request to Review Treatment (UR): •Form 45442: Request for Assistance Request for IME: None Request for Appeal or IRO/IMR: None Complaint: None Miscellaneous: Use the MWR FCM referral form

Communication	Open communication is allowed with the authorized treating physicians and any questions may be asked by the MCM. ***https://www.in.gov/wcb/insurance-carriers/nurse-case-manager-guidelines/ - Nurse Case Manager Guidelines:*** The Nurse Case Manager (NCM) must inform the injured worker that they may require that the NCM not be present during a medical examination. If the NCM meets with the physician before or at the conclusion of a medical appointment, the injured worker must be invited to participate as well.
Other	**IC 22-3-3-6(h)**: "The employer (carrier) upon proper application, or the WC board, shall have the right in any case of death to require an autopsy at the expense of the party requesting the same. If after a hearing, the WC board orders an autopsy and such autopsy is refused by the surviving spouse or next of kin, then any claim for compensation on account of such death shall be suspended and abated during such refusal. No autopsy, except one performed by or on the authority or order of the coroner in the discharge of the coroner's duties, shall be held in any case by any person, without notice first being given to the surviving spouse or next of kin."
Physician Panel/Directory	None Required
Utilization Review (UR) - This section last reviewed and/or updated 4/20/2024 (D. Carter)	
Website/Source	https://www.in.gov/wcb/insurance-carriers/resources/. o Indiana Work Comp Code (IC) 22-3 o Indiana Administrative Code (IAC), Article 1 Workers' Compensation https://www.in.gov/wcb/disputed-claims/.
Carrier UR Certification Licensure Required	No
Treatment Guidelines to be Utilized	IC 22-3-3-4.7: Mandatory State treatment guidelines: Yes for medications, ODG must be followed. Effective 1-1-19: IN SB 369 adopted ODG drug formulary regardless of the date of injury. Any 'N' drug not authorized by FCCI must be sent for peer review and a decision (notification) f non-certification must be sent to both the requesting physician & IW and/or attorney within five (5) business days after receiving the request. FCCI utilizes GENEX Tool box & ODG for treatment guidelines. Per Indiana Title 631, Article 1, Rule 1 [IAC 1-1-32 (11)]: The Indiana Workers' Compensation Board recognizes the Utilization Review Accreditation Commission's (URAC) Workers' Compensation Management 2008 guidelines to medical utilization practices, as well as the Official Disability Guidelines (ODG) published by the Work Loss Data Institute and the American College of Occupational and Environmental Medicine (ACOEM) guidelines. Recommendations from these, and other reputable sources, may be offered as one (1) form of evidence regarding appropriate medical care; however, it will not be considered as conclusive evidence by the single hearing member or the full board.
Drug Formulary (If yes, specify the source)	Not a generic mandate state, but allows for Generic substitution by the Pharmacist if "Brand only" is not indicated by the Physician. For brand name drugs, the Physician must sign the prescription signature line labeled "May not substitute' or "Dispense as Written". Effective 1-1-19: IN SB 369 adopted ODG drug formulary regardless of the date of injury. Any 'N' drug not authorized by FCCI must be sent for peer review and a decision (notification) must be sent to both the requesting physician & IW within five (5) business days after receiving the request. IW may apply to the WC board for a final determination regarding the peer review determination. Failure to notify the requesting physician and the IW within five (5) business days of receipt of the request, will result in an automatic approval of the drug. 1. Exemption applies and allows the use of 'N' drugs during a medical emergency. 2. If the employer/carrier denies the 'N' drug, the request must be sent to a URAC accredited third party (peer review) to make a determination. The prescribing physician and the injured worker must be notified of the determination by the third party no later than five (5) business days after receiving the request. If the employer/carrier fails to provide the notification timely, the physician's request is considered approved and reimbursement of the 'N' drug is authorized. No utilization review of drugs should commence during a medical emergency.
Types of UR	Pre-Authorization, Concurrent review, Retrospective review
Utilization Review Requirements	There is no specific detail regarding what is subject to utilization review.
Outside URAC Accredited Peer Review Contracted Vendors To Be Utilized for 2nd Level Reviews	Must use URAC Accredited contracted Peer Review Providers. CareReview or Claims Eval
Special UR Considerations re Peer Review Specialty Type (State Licensure and Specialty Match)	There are no rules pertaining to Peer licensure or specialty. Same specialty is encouraged.
Timeframe for Verbal Communication re Decision	See below written timeframes
Timeframe for Written (Certified Letter) /Electronic (E-mail or Fax) Communication re Decision	**Pre-Authorization Review:** URAC Standard – within 15 days of receipt of request. Beginning 1/1/19: Review of ODG Formulary "N" drug – within five (5) days of receipt of the request. Follows standard URAC process. Medical services that do not meet the criteria for first level clinical review shall be referred to the peer review level prior to a non- certification or denial. • Modifications by a Peer Reviewer to a determination are not contemplated by the rules but are permitted without restriction. **Concurrent Review:** Per URAC standards, for reductions or terminations in a previously approved course of treatment, FCCI should issue the determination early enough to allow the injured worker or medical provider to request or review and receive a review decision before the reduction or termination occurs For requests to extend a current course of treatment, FCCI should issue the determination within: • 24 hours of the request if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; or • 72 hours of the request, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments. **Retrospective Review:** Indiana does not address retrospective reviews so URAC standards should be used as a guide. Determinations should be made within 30 calendar days of the receipt of request for a utilization review determination. This period may be extended one (1) time for up to 15 calendar days under the following circumstances: • FCCI determines that an extension is necessary because of matters beyond the control of FCCI; and • FCCI notifies the medical provider prior to the expiration of the initial 30 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and • If a medical provider fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the medical provider must be given at least 45 calendar days from receipt of notice to respond to the request for more information.

UR forms to be utilized	• Utilization Review – Additional Information Needed for Review 1-CMWC-3397-NA-04 • Utilization Review – Certification Letter, MCM Auth-Notice of Confirm 1-CMWC-3216-8369-NA-04 • Utilization Review – Notice of Peer Reviewer Determination 1-CMWC-8410-NA-04 (Used for 2nd Level Non-Certification or Partial Non-Certification/Certification) • Utilization Review – Notice of Appeal – Peer Review Determination 1-CMWC-8407-NA-04 (Used for 3rd Level Appeals) Request for Appeal: Disputes not resolved through the Informal Dispute Resolution process may only move forward if an Application for Adjustment of Claim (SF 29109) is filed.
Appeals Process	The injured worker or medical provider may request an appeal within 30 days of the utilization review determination. Appeals of medication denials should be made by petition to the appropriate Single Hearing Member in a disputed case and to the Chairman in non-litigated claims. Per Indiana Title 631, Article 1, Rule 1 [631 IAC 1-1-25], unless otherwise ordered by the board, all claims for physician's fees, attorney's fees, nurses' fees, hospital or medical facility bills, and all disputes pertaining thereto will be scheduled and heard in the same manner as contested claims for benefits. In such cases, the FCCI claims adjuster, the claimant, claimant's attorney, or the medical provider may make their proof by oral testimony, by depositions, or by affidavits, or by all of such methods. Otherwise, FCCI should follow the URAC standards: • Timeframe for issuing determination: The URAC standard is 30 calendar days from receipt of the request for appeal. • Timeframe for appeal submission: The URAC standard is 30 calendar days from the determination date. **State Specific Appeal Process:** Pre-appeal process defined by the Dept. of Insurance under which The URA provides, within one (1) business day of a request by the medical provider, the opportunity to discuss the utilization review non-certification decision: • With the clinical peer reviewer making the initial determination; or • With a different clinical peer, if the original clinical peer reviewer cannot be available within one business day. If a peer-to-peer conversation or review of additional information does not result in a certification, FCCI should inform the medical provider, injured worker's attorney, and/or injured worker of the right to initiate an appeal and the procedure to do so. • Disputes not resolved through the Informal Dispute Resolution process may only move forward if an Application for Adjustment of Claim (SF 29109) is filed. The case is then assigned to a Single Hearing Member of the Worker's Compensation Board for determination of all unresolved issues. The medical provider or injured worker should complete Indiana file form 29109 and mail it to the following address: o Indiana Worker's Compensation Board, 402 W. Washington Street, Room W196, Indianapolis, Indiana, 46204-2753 • At the hearing, each party presents evidence. The injured worker or medical provider has the burden of proving an accidental injury occurred in the course and scope of her employment in order to recover benefits. Medical evidence is extremely important. • After the hearing, the Single Hearing Member will prepare and serve an award upon the parties. The award details the stipulations of parties (issues which are not contested by the parties), findings of fact and the conclusions of law reached. o If either party is dissatisfied with the hearing member's award, an appeal may be filed with the Board. An appeal or Application for Review by Full Board (SF 1042) must be initiated within 30 days of the date of the award. Upon receiving the appeal, the case is set to be heard on the next available Full Board date, which is usually within three (3) months. Appeals are not new hearings, but rather legal arguments made by each side to the full Worker's Compensation Board, which consists of all six Single Hearing Members and the Chairman. After the hearing, the full Board prepares and serves a written award upon the parties. Any further appeal must be made to the Court of Appeals, and then to the Supreme Court of Indiana.
Other	N/A

LICENSURE / CEU - REQUIREMENTS - **This section last reviewed and/or updated 06-30-2023 by Cheryl Richard.**

Website/Source	http://iac.iga.in.gov/iac/; https://www.in.gov/pla/professions/nursing-home/; https://ncsbn.org/compacts.page; Indiana Code 25-23 Sections 1-11; 1-16.1 ; Indiana Administrative Code 848-1
Renewals	**Indiana Code 25-23 Sections 1-16.1 & 848 Indiana Administrative Code 1-1-8**: Renewal every 2 years. Registered Nurse (RN) licenses expire on October 31st of every odd-numbered year, regardless of the issuance date. The renewal fee is $50.00. If you fail to renew by the expiration date, you will be accessed a $50.00 late fee.
Licensure by Endorsement	**IN Admin. Code, Title 848, Article 1-1-7**: A registered nurse who was originally licensed by the NCLEX or the SBTPE in another jurisdiction will be accepted for registration in Indiana by endorsement from the board that granted the original license if the applicant is of good moral character, has graduated from high school or the equivalent thereof and a state approved program in registered nursing (Verification can be done through either **www.nursys.com** or by sending the verification form contained withing the licensure application to the originating state for completion). Application must be accompanied by photograph & proof of current licensure in another jurisdiction. Applicants applying for an initial license shall submit to a national criminal history background check. ***Note that if applying for a compact licensure in IN, the criminal background check and fingerprinting required for initial application must be submitted after the application for licensure is submitted.*** Applicant will receive an email from the IN Board of Nursing with the official date the application was processed. Fingerprints must be submitted on or after the date of this email notice for the CBC to be considered valid and timely. CBCs conducted prior to the email notice date will not be considered. Applicants who reside out of state, or are physically unable to go to a location to be fingerprinted may use MorphoTrust Card Scan Processing Program. Applicants should complete the entire registration process after which a confirmation number will be supplied. This number should be retained by the applicant for tracking purposes. The confirmation number must be included in with your fingerprint card when it is submitted to MorphoTrust for proper processing. Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards. Applicants need to make sure the following information is completed on the fingerprint card: Full name, Date of Birth, and Address. Please include the payment confirmation number provided at the end of making your payment with your card (if you pre-paid). The fingerprint card along with the appropriate fee, if required and not paid by Escrow Account or Credit Card at the end of registration, should then be sent to the following address (for tracking & security reasons, it is recommended that a shipping service with tracking service be utilized): MorphoTrust USA, Indiana Processing, 3051 Hollis Drive, Suite 310, Springfield, IL 62704. Please include at least two (2) means of contact for each applicant for which a fingerprint card is submitted to allow MorphoTrust to ask any questions related to the processing of the fingerprint card (for example, a daytime and evening telephone number or a cell phone number and email address, etc.). Applicants wishing to verify that a fingerprint card has been processed may call 877-472-6917. Please allow 3 days from date of receipt before contacting MorphoTrust regarding processing status. The cost of the criminal background check and fingerprinting is the responsibility of the applicant and is separate from the licensure application fee.
Compact State	Yes - New NLC Rules will take effect on January 2, 2024, including one that requires nurses moving from one compact state to another compact state to apply for licensure in their new Primary State of Residence (PSOR) within 60 days.
QRP or Other Registration Requirements	No

CEU Requirements	No continuing education requirements for licensure renewal; however, RNs and LPNs attempting to renew a license that has been expired for more than 3 years AND who are not currently licensed in another jurisdiction will be required to demonstrate continued competence to practice. For licensees expired 10 years or less, this requirement is satisfied upon providing proof of completing 24 contact hours (6 hours each in 4 subjects as noted below) of continuing education for nurses from an accredited provider of CE for nurses: 6 hours on 'Assessment' 6 hours on 'Documentation' 6 hours on 'Pharmacology' 6 hours on 'Legal / Ethics'