IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	Physician Profession Name	0 3 6 Profession Code
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed _____ months of postgraduate clinical training in _____
(Name of Specialty Program)

from _____ to _____ at the following hospital:
MM/DD/YYYY **MM/DD/YYYY**

Hospital: _____

Number and Street: _____

City, State and Zip Code: _____

I further certify that at the time of such training the program was accredited by:

- ☐ the ACGME
- ☐ the AOA
- ☐ the CFPC, RCPSC or FMLAC (Canadian Programs)
- ☐ not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: _____

Signature of Postgraduate Clinical Training Program Director: _____

Date of this Certification: _____

Telephone No: _____

University/Hospital
S E A L

(If no seal, attach letter on letterhead stating no seal exists.)