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 ACCEPTANCE AND ENROLLMENT FOR A LIMITED TEMPORARY LICENSE

SUPPORTING DOCUMENT

TEMP-LTD

1 3 0
Profession Code

NOTE: *An applicant shall not commence limited specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Financial and Professional Regulation.*

APPLICANT: ***Complete Sections 1-3 of this form and forward it to the hospital/institution where you are currently enrolled in residency training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
	__ __ / __ __ / __ __ __ __ Month Day Year	__ __ __ - __ __ - __ __ __ __

OUT-OF-STATE PROGRAM DIRECTOR: ***Complete Parts A-F, sign, affix official seal and return to the applicant.***

A. HOSPITAL / INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
	__ __ / __ __ / __ __ __ __ Month Day Year	__ __ / __ __ / __ __ __ __ Month Day Year
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE)	E. SPECIALTY / RESIDENCY NAME	
F. BUSINESS TELEPHONE NUMBER Area Code (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___		

I do hereby declare that the above-named applicant is a resident in good standing in the above ACGME/AOA accredited training program.

Signature of Program Director

SEAL

Print Name of Program Director

Date

ILLINOIS PROGRAM DIRECTOR: ***Complete the remainder of this form, sign, affix official seal and submit with the application for the above-named applicant.***

A. HOSPITAL / INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
Rush University Medical Center	__ __ / __ __ / __ __ __ __ Month Day Year	__ __ / __ __ / __ __ __ __ Month Day Year
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE) Department of GME 600 S. Paulina, Suite 403 Armour Academic Chicago, IL 60612	E. SPECIALTY / RESIDENCY NAME	F. YEAR OF POSTGRADUATE TRAINING
G. BUSINESS TELEPHONE NUMBER Area Code (3 1 2) 9 4 2 - 2 7 2 9		

I do hereby declare that the above-named applicant has been accepted for limited specialty/residency training in Illinois as indicated above for a period not to exceed six (6) months. I further hereby declare that I assume full supervisory responsibility for the individual during the period specified.

Signature of Illinois Program Director

SEAL

Type or Print Name of Illinois Program Director

Date