

INSTRUCTION SHEET

PODIATRIC PHYSICIANS

*In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.*

Examination Acceptance of Examination Endorsement of License Restoration

BEFORE COMPLETING THE APPLICATION PACKAGE, read each of the 4 steps below in the order that they are listed, then follow the directions as they apply to you. This will aid you in accurately completing your application and eliminate any delay in processing. **THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT.** If you are issued a permanent license, please be advised that your license will expire on January 31 of each odd-numbered year.

- Step 1. Use the **REFERENCE SHEET (CHART I)** to select the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee, and record that information in **PART I** (page one) of the **Application for Licensure and/or Examination**.
- Step 2. Proceed with **PART II** (page one) and complete all applicable information requested on all 4 pages of the **Application for Licensure and/or Examination**.
- Step 3. The remainder of this form contains specific instructions for each Licensure Method. Locate the instructions for the Licensure Method you recorded in **PART I** (page one), of the **Application for Licensure and/or Examination** and follow those instructions only.

NOTE: All documents in a foreign language that are required to be submitted with an application or for any other purpose in connection with licensure must be accompanied by an original, notarized translation that has been performed by a person, other than the applicant, who is fluent in both English and the language of the document(s). The translator shall certify to the above requirements as well as to the accuracy of the translation.

- Step 4. Contact the Department of Financial and Professional Regulation at 1-800-560-6420 if you need assistance.

NOTICE

The Illinois Controlled Substances Act requires a separate registration for each place of business or professional practice where controlled substances are located or stored. A separate registration is not required for every location at which a controlled substance may be prescribed.

Enclosed is an application for controlled substances licensure.

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov

EXAMINATION

***In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.***

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document **ED** must be completed by a school official of the Podiatric Medicine college/university indicating graduation. Completed document **must have school seal affixed**.
3. Instruct the National Board of Podiatric Medical Examiners to forward proof of your having successfully completed Part I and Part II of their examination directly to Continental Testing Services, Inc.
4. If you have ever held a license as a podiatric physician or a related license, Supporting Document **CT** must be completed by the jurisdiction of original licensure and the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** to you to be submitted with your application.
5. Effective July 1, 1992, you must successfully complete a minimum of one year post-graduate training approved by the Council on Podiatric Medical Education Association. Supporting Document **TN-POD** must be completed verifying successful completion of the one year post-graduate training. Direct the Residency Program Director/Preceptor to forward the completed form to you in a sealed envelope to be submitted with your application.
6. If you have completed the one-year post graduate training, the **TN-POD** form should be completed and submitted with your application. Your temporary license must also be returned with this form.
7. Fee payment is indicated on **REFERENCE SHEET, CHART I**. Fee payment must be in the form of a certified check or money order made payable to Continental Testing Services, Inc.
8. Forward four-page application, supporting documents, the National Board of Podiatric Medical Examiners (NBPME) blue scan form, and fee payment to Continental Testing Services, Inc., P.O. Box 100, LaGrange, Illinois 60525-0100; *or*
9. **Apply Directly On-Line**. Register for the examination by referring to the Continental Testing Web site (www.continentaltesting.net) for information on how to apply for the examination on-line and pay the test fee by credit card.

ACCEPTANCE OF EXAMINATION

***In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.***

NOTE: Applicants applying for licensure on the basis of Acceptance of Examination must have successfully completed Parts I and II of the National Board of Podiatric Medical Examiners Examination, as well as a Clinical Competency Examination (PMLEXIS).

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting document **ED** must be completed by a school official of the Podiatric Medicine college/university indicating graduation. Completed document **must have school seal affixed**.
3. Instruct the National Board of Podiatric Medical Examiners to forward proof of your having successfully completed Part I and Part II of the National Board of Podiatric Medical Examiners and the PMLEXIS to the Division of Professional Regulation.
4. If you have ever held a license as a podiatric physician or a related license, Supporting Document **CT** must be completed by the jurisdiction of original licensure and the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** to you to be submitted with your application.
5. Effective July 1, 1992, you must successfully complete a minimum of one year post-graduate training approved by the Council on Podiatric Medical Education Association. Supporting Document **TN-POD** must be completed verifying successful completion of the one year post-graduate training. Direct the Residency Program Director/Preceptor to forward the completed form to you in a sealed envelope.
6. Fee payment is indicated on **REFERENCE SHEET, CHART I**. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.
7. Forward four-page application, supporting documentation and fee payment to: Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

ENDORSEMENT

*In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.*

NOTE: Applicants applying for licensure on the basis of endorsement, must have successfully completed Parts I and II of the National Board of Podiatric Medical Examiners Examination, and show proof of successful completion of a clinical competency examination (PMLEXIS) completed in another state which is equivalent to Illinois requirements.

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document CT must be completed by the jurisdiction of original licensure and the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form CT to you to be submitted with your application.
3. Supporting Document ED must be completed by a school official of the college/university from which your Doctor of Podiatric Medicine Degree was awarded. Completed document must have school seal affixed. **This form must be submitted with your application.**
4. Instruct the National Board of Podiatric Medical Examiners to forward proof of having successfully completed Parts I and II of their examination to the Division of Professional Regulation.
5. For consideration of a waiver of requirements of passage of the Clinical Competency Examination, the Department shall examine your endorsement application to determine whether the requirements in that jurisdiction on the date of licensing were substantially equivalent to the requirements then in force in this State. Full consideration will be given to your podiatric education, training and experience, including, but not limited to your having submitted one of the following:
 - a) Proof of certification by American Specialty Board; *or*
 - b) Proof of achievement of special honors or awards; *or*
 - c) Proof of publication of articles in recognized and reputable journals; *or*
 - d) Proof that you have written or participated in the writing of textbooks in podiatric medicine.
6. Effective July 1, 1992, you must successfully complete a minimum of one year post-graduate training approved by the Council on Podiatric Medical Education Association. Supporting Document TN-POD must be completed verifying successful completion of the one year post-graduate training. Direct the Residency Program Director/Preceptor to forward the completed form to you in a sealed envelope.
7. Fee payment is indicated on **REFERENCE SHEET, CHART I**. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation, Division of Professional Regulation.
8. Forward four-page application, supporting documentation, and fee payment to: Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P.O Box 7007, Springfield, Illinois 62791.
9. Copy of Act and Rules which were in effect in the jurisdiction of original licensure.

RESTORATION

***In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.***

IMPORTANT NOTICE: These Restoration Instructions apply only to those podiatrists whose licenses have been on inactive status, or in non-renewed status, for five or more years.

If your license has been inactive, or in non-renewed status, for less than five years, you should contact the Department of Financial and Professional Regulation at 1-800-560-6420 for detailed instructions on how to restore it to active status.

NOTE: Based upon the Podiatric Medical Licensing Board's evaluation of your application, you may be required to submit additional documentation and/or appear for oral interview before the Board to determine current competency to practice as a podiatric physician. Additionally, you may be required to successfully complete the clinical competency examination conducted by this Department.

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document CT must be completed by the U. S. jurisdiction where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form CT to you to be submitted with your application.
3. Supporting Document RS must be completed. If this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation, Division of Professional Regulation, at 1-800-560-6420.
4. Submit one of the following:
 - a) Supporting Document VE must be completed to provide documentation of active practice; *or*
 - b) Copy of DD214 if restoring after active military service; *or*
 - c) Proof of successful completion of a written clinical competency examination (PM LEXIS) within one year of application for restoration.
5. All applicants for restoration of a Podiatric Physician license in Illinois must submit proof of having completed 100 hours of Continuing Education during the 2 years prior to restoration. A minimum of 50 hours. This must be verified by the submission of certificates of attendance provided by approved continuing education sponsors, validated by the Illinois Podiatric Medical Association and approved by the Department of Financial and Professional Regulation, Division of Professional Regulation. A maximum of 50 hours may be earned through non-supervised individual activities.
6. Fee payment amount is indicated in the Official Use Only Box on Supporting Document RS. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.
7. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966.**"

"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse.**"

IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966.**"

"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse.**"

REFERENCE SHEET

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change examination dates, filing deadlines and fees if prevailing circumstances necessitate such action.

CHART I - PROFESSION NAME, PROFESSION CODE, LICENSURE METHOD & FEE

<u>Profession Name</u>	<u>Profession Code</u>	<u>Licensure Method</u>	<u>Test Fees</u>
Podiatric Physician	016	Acceptance of Examination	\$ 400.00
Podiatric Physician	016	PM LEXIS (Part III) Examination	\$1,034.00
Podiatric Physician	016	Endorsement	\$ 400.00
Podiatric Physician	016	Restoration	See Supporting Document RS

CHART II - EXAMINATION / APPLICATION

You must register online to complete the Illinois application for examination by paying the examination fee and submitting all supporting documents to Continental Testing Services, Inc. (CTS) by their deadline. This includes the Part III registration form from the National Board of Podiatric Medical Examiners (NBPME).

Complete the Illinois application for examination at: www.continentaltesting.net and pay the required examination fee with a credit card (Visa or MasterCard); and

From the NBPME website download the Part III examination registration form at www.aplme.com. Complete this form and mail to Continental Testing Services (CTS).

Once Continental Testing Services determines your eligibility to test, you will receive your Authorization to Test (ATT) from Prometric, you may then contact them to schedule your testing appointment.

NOTE: The Test Fee is for the cost of the examination only and is not transferable from one exam to another.

CHART III - EXAMINATION DATES

For information on **Examination Dates, Application Deadlines, and Test Center Codes** please visit CTS at www.continentaltesting.net.

APPLICATION FILING DEADLINES WILL BE STRICTLY ENFORCED.

REQUEST FOR ASSISTANCE

If assistance is needed, direct your request (based upon your licensure method) to:

Licensure Methods **Except** Examination (**US ONLY**)

1-800-560-6420

TTY

1-866-325-4949

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

Examination Licensure Method **Only**

1-708-354-9911

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Podiatric Physician

*In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.*

Before you mail your application, check the following items to make sure your application is complete!

FOUR-PAGE APPLICATION REVIEW	COMPLETED
Part I. Application Category Information	
Part II. Applicant Identifying Information	
Part III. Education Information	
Part IV. Record of Licensure Information	
Part V. Record of Examination	
Part VI. Personal History Information	
Part VII. Examination Coding Information (if applicable)	
Part VIII. Child Support and/or Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS	SUBMITTED
4-page Application for Licensure and/or Examination	
Application Fee--refer to Reference Sheet for licensure method to determine fee.	
Supporting Document CCA must be completed and submitted with each application. Your application will not be processed without completion of this form.	
ED Form completed by a school official of the Podiatric Medicine college/ university, with the school seal affixed.	
CT (Certification of Licensure) Form completed by state of original licensure and state of current licensure where you have most recently been practicing.	
TN-POD Form verifying one year post-graduate training approved by the Council on Podiatric Medical Education Association (effective July 1, 1992) (applicable that date and forward).	
VE (Verification of Employment) Form (if applicable).	
RS (Restoration) Form (if applicable). If this form was not included in the application packet, you must obtain one by contacting the Department at 800/560-6420.	
Copy of DD214 if restoring from active military service.	
Restoration Applicants: Submit proof of having completed 100 hours of continuing education during the two years prior to restoration.	

APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is **VOLUNTARY**. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit **PROOF OF LEGAL NAME change** - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. **FEES ARE NOT REFUNDABLE.**
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. Check the box indicating the appropriate information regarding your application. Military Military Spouse Not Military Decline to Answer
 Military service member is defined as: "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE \$
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C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|---|--|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|---|--|

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO. _____ - _____ - _____
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4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
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6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
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8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH ____ / ____ / ____ Month Day Year	10. AGE ____ <input type="checkbox"/> Female <input type="checkbox"/> Male
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11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) _____ -- _____ Home: (____) _____ -- _____ (Area Code) (Area Code) Fax: (____) _____ -- _____ Fax: (____) _____ -- _____ (Area Code) (Area Code)	12. REQUIRED E-MAIL ADDRESS
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NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12 Graduated Received
 High School? Yes No OR G.E.D.? Yes No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED

3. LAST PRELIMINARY SCHOOL LOCATION (City and State)

4. DATE OF GRADUATION
 ____ / ____
 Month Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8 Graduated? Yes No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE		TYPE OF DEGREE EARNED
		FROM	TO	
		Month/Year	Month/Year	

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM	TO	
		Month/Year	Month/Year	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
			(Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

PART VI: Personal History Information <i>(This part must be completed by all applicants)</i>	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>		

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

b) CHART III - Select the examination site you desire and enter Test Center Code:

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c) CHART IV - Find your School of Graduation and enter school code:

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d) Record the number of times you have taken this exam in Illinois or any other state:

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PART VIII: Child Support and Tax Information *(Every applicant is required by law to respond to the following questions)*

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

Are you more than 30 days delinquent in complying with a child support order? Yes No

(NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes? Yes No

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

3. PROFESSIONAL LICENSE NUMBER (if any)
_____ - _____

2. ADDRESS STREET, CITY, STATE, ZIP CODE

4. SOCIAL SECURITY NUMBER
_____ - _____ - _____

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- | | | |
|---|---|--|
| <input type="checkbox"/> Acupuncturists | <input type="checkbox"/> Naprapaths | <input type="checkbox"/> Physician Assistants |
| <input type="checkbox"/> Advanced Practice Registered Nurses | <input type="checkbox"/> Nursing Home Administrators | <input type="checkbox"/> Podiatrists |
| <input type="checkbox"/> Advanced Practice Registered Nurse - Full Practice Authority | <input type="checkbox"/> Occupational Therapists | <input type="checkbox"/> Professional Counselors |
| <input type="checkbox"/> Athletic Trainers | <input type="checkbox"/> Occupational Therapy Assistants | <input type="checkbox"/> Prosthetists |
| <input type="checkbox"/> Audiologists | <input type="checkbox"/> Optometrists | <input type="checkbox"/> Registered Nurses |
| <input type="checkbox"/> Clinical Psychologists | <input type="checkbox"/> Orthotists | <input type="checkbox"/> Registered Surgical Assistants |
| <input type="checkbox"/> Clinical Social Workers | <input type="checkbox"/> Pedorthists | <input type="checkbox"/> Registered Surgical Technologists |
| <input type="checkbox"/> Dental Hygienists | <input type="checkbox"/> Perfusionists | <input type="checkbox"/> Respiratory Care Practitioners |
| <input type="checkbox"/> Dentists | <input type="checkbox"/> Pharmacists | <input type="checkbox"/> Speech Pathologists |
| <input type="checkbox"/> Genetic Counselors | <input type="checkbox"/> Physical Therapists | |
| <input type="checkbox"/> Licensed Clinical Professional Counselors | <input type="checkbox"/> Physical Therapy Assistants | |
| <input type="checkbox"/> Licensed Practical Nurses | <input type="checkbox"/> Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.) | |
| <input type="checkbox"/> Licensed Social Workers | | |
| <input type="checkbox"/> Marriage and Family Therapists | | |
| <input type="checkbox"/> Medication Aide | | |

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? * | <input type="checkbox"/> | <input type="checkbox"/> |

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Email

Date

* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

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for double-sided printing.**

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

FOR EXAM USE ONLY

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

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. _____ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code (____) _____ - _____	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize _____ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.
Name of Licensing Agency or Board
Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS
 A. The applicant has written is scheduled to write the following examination:
 _____ Name of Examination _____ Date of Examination
 B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

<input type="checkbox"/> Examination (Administered in Your State)	<input type="checkbox"/> Reciprocity with (State) _____
<input type="checkbox"/> National (Name) _____	<input type="checkbox"/> Waiver/Grandfather
<input type="checkbox"/> State Constructed _____	<input type="checkbox"/> Credentials
<input type="checkbox"/> Other (Name) _____	<input type="checkbox"/> Other (Describe) _____
<input type="checkbox"/> Endorsement of License (State) _____	
Acceptance of Examination Results _____	
(Administered in Another State)	

F. CURRENT LICENSURE STATUS <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain) _____ _____ _____	G. IF LICENSED BY EXAMINATION, RECORD SCORES <table border="0"> <tr> <td>Type of Examination</td> <td>Score</td> </tr> <tr> <td>Written</td> <td>_____</td> </tr> <tr> <td>Practical</td> <td>_____</td> </tr> <tr> <td>Other (Describe) _____</td> <td></td> </tr> <tr> <td>Received no Grade Below</td> <td>_____</td> </tr> <tr> <td>Examination Period _____ days _____ hours</td> <td></td> </tr> </table>	Type of Examination	Score	Written	_____	Practical	_____	Other (Describe) _____		Received no Grade Below	_____	Examination Period _____ days _____ hours	
Type of Examination	Score												
Written	_____												
Practical	_____												
Other (Describe) _____													
Received no Grade Below	_____												
Examination Period _____ days _____ hours													

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

- A. Is there now or has there ever been any formal action commenced against the applicant? Yes No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.) Yes No

PART V - RECIPROCAL REGISTRATION

This state does does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

S E A L	_____	_____
	Print Name	Signature
	_____	_____
	Title	Date
	_____	_____
	Agency/Board Street Address	Area Code ()
	_____	_____
	City, State, ZIP Code	Telephone Number

ATTENTION APPLICANT--RETURN EXAM CT TO: Continental Testing Services, Inc.
P.O. Box 100
LaGrange, Illinois 60525-0100

NAME (Last, First, MI):

SS#:

Profession:

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI):

I certify that the information recorded herein is true and correct according to the official records of this institution.

SS#:

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____, 20____.

Profession:

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 100/1 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 RESIDENCY/PRE-CEPTORSHIP TRAINING

SUPPORTING DOCUMENT

TN-POD

APPLICANT: Complete the applicant section of this form. Forward the form to the individual who will certify 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. _____ Profession Name _____ Profession Code	
6. MAIDEN OR GIVEN SURNAME		
7. DATES OF TRAINING From ____/____/____ To ____/____/____ Month Day Year Month Day Year	8. ILLINOIS TEMPORARY LICENSE NUMBER ISSUANCE DATE	
9. NAME OF RESIDENCY/PRECEPTORSHIP TRAINING PROGRAM PARTICIPATED IN OR COMPLETED	10. RESIDENCY PROGRAM DIRECTOR/PRECEPTOR NAME	

RESIDENCY PROGRAM DIRECTOR/PRECEPTOR

Complete the remainder of this form. Return the completed form to the applicant in a sealed envelope.

A. RESIDENCY PROGRAM DIRECTOR/PRECEPTOR NAME	B. OFFICE/FACILITY NAME
C. TELEPHONE NUMBER OF ABOVE Area Code (____) ____ - ____	D. OFFICE/FACILITY STREET ADDRESS
E. APPLICANT'S TRAINING DATES From ____/____/____ To ____/____/____ Month Day Year Month Day Year	F. OFFICE/FACILITY CITY, STATE, ZIP CODE
G. WAS RESIDENCY/PRECEPTORSHIP TRAINING PROGRAM SATISFACTORILY COMPLETED? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If No, attach a detailed explanation.</i>	H. INDICATE FACILITY NAME WHERE RESIDENCY/PRECEPTORSHIP WAS COMPLETED

I certify that the information recorded herein is true and correct according to the official records of this office/facility.

_____ Date

_____ Signature of Residency Program Director/Preceptor

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this ____ day of _____, 20__.

_____ Date of Expiration

_____ Signature of Notary Public

INSTRUCTIONS FOR CONTROLLED SUBSTANCES REGISTRATION

****READ AND FOLLOW INSTRUCTIONS CAREFULLY****

If you hold a non-renewed controlled substances registration, you must reinstate that registration. Do not apply for a new registration.

Every person who prescribes and/or stores or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.

A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or dispensed.

1. If you do not properly complete Parts I through VII (front and back) of the application, the application will be returned to you and licensure will be delayed.
2. It is **mandatory** that the permanent mailing address and/or business address be a street address. **P.O. boxes are not acceptable. Your Controlled Substances registration must be issued to a street address.**
3. If your professional application is pending, write "pending" in Part IV. A controlled substances registration **will not** be issued until your professional license has been issued. A controlled substances registration **will not** be issued to individuals holding a temporary license.
4. You **must** circle each drug schedule for which you are applying in Part III.
5. You **must** complete and submit the CCA Form. Your application will not be processed without completion of this form.
6. Submit the \$5 application fee. Make check or money order payable to the Department of Financial and Professional Regulation (IDFPR). **The fee is non-refundable.** Mail the completed application and fee to:

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7007
Springfield, Illinois 62791

A State controlled substances registration is a **prerequisite** for Federal controlled substances registration. The address on your Illinois controlled substances registration must be exactly the same address as your Federal registration. For information concerning Federal registration, you must contact:

Drug Enforcement Administration
230 South Dearborn, Suite 1200
Chicago, Illinois 60604
Telephone: 312/353-7875
Web site: www.dea.diversion.usdoj.gov

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

Disclosure of your U.S. social security number, if you have one, is **mandatory**, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSION NAME Controlled Substances	2. PROFESSION CODE - Check applicable box <input type="checkbox"/> 319 Dentist <input type="checkbox"/> 346 Optometrist <input type="checkbox"/> 316 Podiatrist <input type="checkbox"/> 390 Veterinarian <input type="checkbox"/> 336 Physician <input type="checkbox"/> 377 APRN-FPA	3. LICENSURE METHOD Registration	4. FEE \$5
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PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO - - - - -
4. PERMANENT MAILING ADDRESS CITY STATE/COUNTRY ZIP CODE COUNTY - - - - - + - - - - -		
5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED _____		
		6. EMAIL ADDRESS (REQUIRED)

<p>7. If you will not be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.</p> <p><input type="checkbox"/> I will not be storing or dispensing controlled substances, including samples.</p>	<p>8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)</p> <hr/> <p>9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY</p> <p>Work () _____ FAX () _____ Area Code Area Code</p> <p>Home () _____ FAX () _____ Area Code Area Code</p>
---	--

PART III: Drug Schedule

PART IV: Professional Activity

Circle the schedules for which you are applying:

II III IV V

Practitioner--Check and complete one of the following:

Professional License Number

Dentist 019 - _____

Optometrist 046 - _____

Physician 036 - _____

Podiatrist 016 - _____

Veterinarian 090 - _____

APN-FP 277 - _____

NAME (Last, First, MI):

SS#:

Profession:

PART V: Personal History Information (This part must be completed by all Applicants)	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.		
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

PART VI: Child Support Information (every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

Are you more than 30 days delinquent in complying with a child support order? Yes No

(NOTE: If you are not subject to a child support order, answer "no.")

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

_____ Date of Application _____ Signature of Applicant

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

***Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.***