# INSTRUCTION SHEET

**PHYSICIAN AND SURGEON**

- **Temporary Licensure**

**Limited Temporary Licensure**
**Transfer of Temporary Licensure**
**Extension of Temporary Licensure**

***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.***

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**Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.**

# FEES

| PROFESSION NAME | PROFESSION CODE | LICENSURE METHOD | APPLICATION FEE |
|---|---|---|---|
| Temporary Physician Licensure | 125 | Nonexamination | $230.00 |
| Temporary Physician Transfer | 125 | Nonexamination | $ 20.00 |
| Temporary Physician Extension/Reissue | 125 | Nonexamination | $100.00 |
| Limited Temporary Physician Licensure | 130 | Nonexamination | $100.00 |
| Limited Temporary Physician Transfer/Reissue | 130 | Nonexamination | $ 20.00 |

# EDUCATIONAL REQUIREMENTS

In order to be considered for licensure in Illinois, an applicant must have completed a 6 year postsecondary course of study comprising of:

**Preprofessional Education**

2-year course of instruction, in a liberal arts or medical college.

**Professional Education**

Graduation from a medical or osteopathic college officially recognized by the jurisdiction in which it is located for the purpose of receiving a license to practice medicine in all of its branches comprised of:

1. at least 2 academic years of study in the basic medical sciences; and

2. 2 academic years of study in the clinical sciences while enrolled in the medical college which conferred the degree and with the stipulation that the core rotations of which must have been either:

   a) in clinical teaching facilities owned, operated, or formally affiliated with the medical college which conferred the degree; or

   b) under contract in teaching facilities owned, operated, or affiliated with another medical college which is officially recognized by the jurisdiction in which the medical school which conferred the degree is located; or

   c) graduated from a medical or osteopathic college accredited by the Liaison Committee on Medical Education or the American Osteopathic Bureau of Professional Education.

# PROFESSIONAL CAPACITY QUALIFICATIONS

In determining professional capacity, the Department shall consider, **but not be limited to**, the following activities:

**Medical Research**

Medical research shall be human clinical research that is consistent with the requirements of the Federal Food and Drug Administration, and the Consumer Product Safety Commission.

**Special Training or Education**

Specialized training or education shall be clinical training or clinical education such as the following:

a. Clinical training which takes place in a residency training program recognized by the Department.

b. Clinical medical practice in the National Health Service.

c. Continuing medical education (CME) recognized by the American Council on Continuing Medical Education (ACCME), the American Osteopathic Association (AOA), or continuing medical education in accordance with the adopted Rules and Regulations of the Department.

d. Postgraduate education in basic or related medical sciences.

**Published**

Publication in medical or scientific journals of original work in clinical medicine which are listed by the Cumulative Index Medicas (CIM).

**Public Clinical Research**

Clinical research or professional clinical medical practice in public health organizations (e.g. World Health Organization (WHO), Malaria Prevention programs, United Nations International Children's Emergency Fund (UNICEF) programs, both national and international.

**Federal Clinical Research**

Having been engaged in clinical research or clinical medical practice at a veterans, military, or other medical institution operated by the federal government.

**Other**

Other professional or clinical medical activities such as:

a. Presentation of papers or participation on panels as a faculty member at a program approved or recognized by the American Medical Association (AMA) or its affiliate, the American Osteopathic Association (AOA) or its affiliate, or a specialty society or equivalent recognized by the medical community;

b. Experience obtained as a Visiting Professor in accordance with Section 18(a) of the Illinois Medical Practice Act of 1987.

# APPLYING FOR LICENSURE

***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.***

**GENERAL INSTRUCTIONS**

1. Read these instructions; then read "Filing Instructions for Temporary Licensure," to determine the basis under which you must comply and the documentation and forms you must submit.

2. **All documents in a foreign language** must be accompanied by an original, notarized translation that has been transcribed 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.

**Forward the four-page application, supporting documentation, and fee to:**

**Department of Financial and Professional Regulation**
**ATTN: Division of Professional Regulation**
**P.O. Box 7086**
**Springfield, IL 62791**

3. Read the applicable section of the "Forms Completion Guide" (pages 8 through 10) for information concerning 4-page application and Supporting Documents prior to completing the applicable forms. You may photocopy any of the enclosed forms if additional forms are needed.

4. To determine the fee, consult the Fee Section, page 2. Fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation.

5. After receipt and review of the completed application by the Department, if determination of eligibility cannot be made, you will be notified to appear for an interview before the Medical Licensing Board at a regularly scheduled board meeting.

6. The temporary license is issued to the hospital where clinical training is to be completed. All inquiries and correspondence from the Department **will** be directed to the Graduate Medical Education (GME) office of the hospital.

7. All applications for temporary licensure, including limited licenses, reissued licenses, transfers, and extensions must be on file a minimum of **60 days prior to the commencement date of the training**.

8. The GME office of the hospital may contact the Department directly to obtain the updated status of your application. Deficiency notices and all other correspondence regarding your application will be directed to the GME office. If you need any further assistance, please contact the GME office at the hospital.

**FILING INSTRUCTIONS FOR TEMPORARY LICENSURE**

**Temporary Licensure for Individuals who Graduated from Approved U.S. or Canadian Colleges**

Graduates of approved U. S. or Canadian colleges, must submit the following in order to be considered for temporary licensure (read the above *General Instructions* before proceeding):

a. Application for Licensure;

b. **CCA** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. **VE-PC** Verification of Employment/Experience--Professional Capacity;

**FILING INSTRUCTIONS FOR LICENSURE *(cont'd)***

e. **CT** Certification of Licensure, if applicable;

f. **CA-MED** Certification of Acceptance for Specialty/Residency Training (this form must be signed by the residency program director);

g. Fee;

h. An official transcript verifying a minimum of 2 years liberal arts/pre-medical education with school seal affixed;

i. An official medical transcipt listing the type and exact date the degree was conferred with the school seal affixed if applicant has graduated.

- For applicants who have not officially graduated, submit an official transcript verifying medical education completed to date, with school seal affixed, **ALONG** with the ED-MED (Certification of Graduation) completed by the dean or registrar of the medical school. ED-MED and transcript may **not** be certified more than 30 days prior to the graduation date.

j. Individuals who graduated from a medical or osteopathic college more than 5 years prior to date of application for licensure, not actively engaged in the practice of medicine or engaged in a formal program of medical education in another state, territory, country, or province in addition to meeting all requirements for licensure, must submit documentation to the department evidencing professional capacity since graduation from medical school. Refer to page 3 for specific information regarding acceptable documentation to evidence continuing clinical skills.

**Temporary Licensure for Individuals who Graduated from NON-LCME Approved Colleges**

Individuals who did not graduate from medical or osteopathic college accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools in conjunction with the Liaison Committee on Medical Education, or the American Osteopathic Bureau on Professional Education must submit the following in order to be considered for temporary licensure (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure;

b. **CCA form must be completed by all applicants**;

c. **PH** form must be completed by all applicants;

d. **VE-PC** Verification of Employment/Experience--Professional Capacity;

e. **CT** Certification of Licensure, if applicable;

f. An official transcript with school seal affixed verifying a minimum of 2 years liberal arts/pre-medical education (see *Educational Requirements*, page 2);

g. Medical school transcript with school seal affixed (see *Educational Requirements*, page 2);

h. A copy of your original medical school diploma if graduation date and degree conferred is not on transcript;

i. **CA-MED** Certification of Acceptance for Specialty/Residency Training (this form must be signed by the residency program director);

j. **ED-NON** Certification of Education;

k. Verification of E.C.F.M.G.. certification;

l. Fee;

***International Medical Graduates***

*Original transcripts or its equivalent (i.e., statement of marks obtained, academic records of studies, etc.) are necessary for a determination of eligibility standards. Subsequent to review originals will be returned via regular mail. If you would like original documents returned other than by regular mail, you must provide a prepaid envelope.*

## FILING INSTRUCTIONS FOR LICENSURE *(cont'd)*

m. Individuals graduating from a Fifth Pathway program must submit, in addition to all of the documents requested above, verification of completion of an approved Fifth Pathway program.

n. Individuals must submit proof of completion of internship or social service if required prior to the granting of their degree.

o. Individuals who graduated from a medical or osteopathic college more than 5 years prior to the date of application for licensure, not actively engaged in the practice of medicine or engaged in a formal program of medical education in another state, territory, country, or province, in addition to meeting all requirements for licensure, must submit documentation to the Department evidencing professional capacity since graduation from medical school. Refer to page 3 for specific information regarding acceptable documentation to evidence continuing clinical skills.

**Transfer of Temporary License**

In order to transfer your temporary license to a different residency training program within the same facility or to another facility, you must submit the following (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure

b. **CCA** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. Your current temporary license must be returned to the Department by the clinical teaching facility/institution.

e. **CA-MED** Certification of Acceptance for Speciality/Residency (This form must be signed by the residency program director.)

f. Fee.

***Prior to a new license being issued, the original license must be returned to the Department. A copy of the license may be retained by the hospital.***

**Extension/Reissue of Temporary License**

Temporary licenses may be extended only in the following documented situations: 1) serving full-time in the Armed Forces; 2) an incapacitating illness; 3) continuance of a residency training program in order to meet the remedial requirements to retake the licensure examination, 4) continuance of a residency training program within ACGME or AOA guidelines. **The Department allows for a 14-day extension beyond the expiration of the temporary license without filing an application to extend.** In order to request an extension submit the following (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure

b. **CCA** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. A letter from the residency program director advising why an extension is being requested;

e. **CA-MED** Certification of Acceptance for Specialty/Residency (this form must be signed by the residency program director);

f. Fee.

***Prior to a new license being issued, the original license must be returned to the Department. A copy of the license may be retained by the hospital.***

**Limited Temporary License**

To be eligible for a 6-month limited temporary license, an applicant must be enrolled in an approved training program in another state and be accepted in an approved clinical training program in Illinois due to the absence of adequate facilities in the other state. In order to request a limited temporary license, submit the following (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure;

b. **CCA** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. **CT** Certification of Licensure, if applicable;

e. **TEMP-LTD** Certification of Acceptance for a Limited Specialty/Residency Program in Illinois (this form must be signed by the Illinois and out-of-state residency program director); and

f. Fee.

# FORMS COMPLETION GUIDE

This guide will help you complete the forms needed to apply for licensure. For information regarding the forms which you will be required to submit, refer to the section entitled *Filing Instructions for Temporary Licensure*.

**Application for Licensure and/or Examination**

Provide all applicable information requested on all four pages of the application. The following will assist you in this endeavor.

1. Part 1-A--Use the Reference Sheet (Chart 1) to record the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee.

   Part 1-B--Check the box indicating the appropriate information regarding your application.

2. Part II--Enter all applicable information requested.

3. Part III--Education Information.

   a. Numbers 1 through 5--Enter all applicable information requested.
   b. Number 6--Indicate every college, university or medical school attended, along with dates of attendance.
   c. Number 7--Indicate all postgraduate clinical training including specialty/residency/intern/training.

4. Part IV--Record of Licensure Information--Individuals licensed in a U.S. jurisdiction or a foreign country or province must state whether or not they have ever held licensure (either permanent or temporary) to practice as a physician/surgeon.

5. Part V--Record of Examination--List all examinations taken to qualify for physician licensure; i.e., FLEX, National Boards, and USMLE. Each examination attempt and date taken must be shown.

6. Part VI--Personal History Information--You must answer all 6 questions either "yes" or "no." If any of your responses to numbers 1 through 6 are "yes," submit a detailed statement explaining your affirmative response(s) and any and all applicable information as indicated below. Upon completion of your application, further review will be required.

   Question 1-2 A certified copy of all court records (other than minor traffic violations) regarding your conviction of a criminal or driving offense in any county, state, circuit or federal court, including a copy of the police report(s); if probation given, verification that probation was completed satisfactorily; a copy of all proceedings regarding the conviction and final disposition of the charge(s) direct from the court(s).

   Submit a statement for each conviction indicating date and place of conviction, nature of the offense, and if applicable, the date of discharge from any penalty imposed.

   Question 3 If you have been issued a Certificate of Relief from Disabilities by the Prisoner Review Board, you must include a copy of the certificate.

**FORMS COMPLETION GUIDE *(cont'd)***

Question 4 A report from any and all physicians, counselors, or therapists from whom you have received treatment for any chronic disease or condition (i.e., chemical/alcohol dependency, depression, etc.). The report must include dates of treatment, method of treatment, diagnosis, and prognosis. Attach a detailed statement advising whether you are currently under treatment.

Submit a copy of each of your treating physician's curriculum vitae and verification of board certification if board certified in a specialty.

If you have been treated as an inpatient/outpatient at any time for any disease or condition, then it will be necessary for you to have the institution(s) submit, directly to this Department, copies of any and all admitting histories, physicals and discharge summaries for each inpatient/ outpatient stay or treatment.

Question 5 A detailed explanation is required if you have 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. Information from every state licensing board or licensing entity must be submitted regarding discipline, probation, suspension, censure, restriction, limitation, or revocation of your license, permit, work letter, or certificate to practice medicine or denial of your privilege of taking an examination. The information from each and every state must include the statement of charges, ALL proceedings regarding charges, and disposition of the charges.

Question 6 If you have ever been discharged other than honorably from any branch of the armed service, or from any city, county, state, or federal position, request the appropriate entity to forward, directly to this Department, any and all information relative to your discharge.

7. Part VII--Do not complete this part.
8. Part VIII--This part must be completed by all applicants.
9. Part IX--Read the certifying statement and then sign and date your application.

**CCA Form** This form is to be completed by all applicants pursuant to ILCS 2105-165(a).

**PH Form** This form must be completed by all applicants.

**FORMS COMPLETION GUIDE *(cont'd)***

| | |
|---|---|
| **VE-PC**<br>**Verification of Employment/ Experience--Professional Capacity** | This form is to be completed by all applicants. Record your work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in your medical practice since graduation from medical school. |
| **CT**<br>**Certification of Licensure** | This document must be completed by the jurisdiction of original licensure and the jurisdiction where you have most recently been practicing. This applies to individuals licensed in a U.S. jurisdiction or foreign country or province. NOTE: You must direct the licensing entity to return the completed form **directly** to you. |
| **CA-MED**<br>**Certification of Acceptance for Specialty/Residency Training** | This form is to be completed by the program director of the specialty/ residency program to which you applied. |
| **ED-MED**<br>**Certification of Graduation** | Current year graduates of approved U.S. or Canadian medical schools, who have not been awarded a medical degree, must submit the ED-MED form, along with an official current transcript, completed by the dean or registrar of the medical school they attended. The ED-MED form and transcript cannot be certified more than 30 days prior to the graduation date. |
| **ED-NON**<br>**Certification of Education** | This form must be submitted by applicants who are graduates of a NON-LCME approved medical school. An official of the school must complete this form with all dates in month/day/year format. |
| **TEMP-LTD**<br>**Certificate of Acceptance and Enrollment for a Limited Specialty/Residency Program** | This form msut be completed and signed by the program director of the Illinois specialty/residency training program for which the applicant is applying and the residency program director for the out-of-state program. |

# LICENSURE METHODS AND DEFINITIONS

*Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.*

| Licensure Methods | Definition |
|---|---|
| Examination | Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department. |
| Endorsement of License | Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued. |
| Acceptance of Examination | Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state. |
| Restoration | Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review. |
| Grandfather/Waiver | Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only). |
| Non-examination | Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals. |

# 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."**

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"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."**

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Temporary Physician

***In order for your application to be processed,***
***<u>ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED</u>***
***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** |
|---|---|
| Application Fee | |
| **CCA** Form | |
| **PH** Form | |
| **CT** (Certificate of Licensure) Form from original and current jurisdictions of licensure | |
| **VE-PC** Form | |
| **CA-MED** Form | |
| **ECFMG Certificate** (copy), if applicable | |
| **Proof of Pre-Medical and Medical Education** | |
| **Medical School Diploma** (copy), if applicable | |
| **ED-NON** Form, if applicable | |
| **5th Pathway/Social Service**, if applicable | |
| **TEMP-LTD** Form (Limited Temporary License Only) | |

**All supporting documents *<u>may not be required</u>*. Please refer to application instructions for your specific method of licensure.**

# APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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. 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 |
|---|---|---|---|
| | ___ ___ ___ | | $ |

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ 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. |
|---|---|---|
| | | __ __ __ – __ __ – __ __ __ __ |

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

__ __ __ __ __ – __ __ __ __

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

__ __ __ __ __ – __ __ __ __

| 6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) | 7. MOTHER'S MAIDEN NAME |
|---|---|
| | |

| 8. PLACE OF BIRTH CITY STATE/COUNTRY | 9. DATE OF BIRTH | 10. AGE |
|---|---|---|
| | __ __ / __ __ / __ __ __ __ (Month / Day / Year) | ____ ☐ Female ☐ Male |

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: ( __ __ __ ) __ __ __ – __ __ __ __ (Area Code)

Home: ( __ __ __ ) __ __ __ – __ __ __ __ (Area Code)

Fax: ( __ __ __ ) __ __ __ – __ __ __ __ (Area Code)

Fax: ( __ __ __ ) __ __ __ – __ __ __ __ (Area Code)

12. **REQUIRED** E-MAIL ADDRESS



**Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.**

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 High School? ☐ Yes ☐ No Received 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 FROM | DATES OF ATTENDANCE TO | TYPE OF DEGREE EARNED |
|---|---|---|---|---|
| | | 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 FROM | DATES OF ATTENDANCE TO | Did You Complete Training? |
|---|---|---|---|---|
| | | Month/Year | Month/Year | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

NAME (Last, First, MI):

SS#:

Profession:

## 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.)***

NAME (Last, First, MI):

SS#:

Profession:

| PART VI: 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. *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.* | | |
| 2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.* | | |
| 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? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.* | | |
| 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.* | | |

## PART VII: 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 VIII: 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.

# ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
# PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

**PH**

| NAME | LAST | FIRST | MIDDLE | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| | | | | __ __ __ – __ __ – __ __ __ __ |

| In order for your application to be evaluated, you must respond to each of the following questions: | YES | NO |
|---|---|---|
| 1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation. | | |
| 2. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? *If yes, attach a separate sheet with complete and accurate explanation.* | | |
| 3. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.* | | |
| 4. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation. | | |
| 5. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.* | | |
| 6. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.* | | |
| 7. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.* | | |

## 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

Date

**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

2. ADDRESS STREET, CITY, STATE, ZIP CODE

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

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.**

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

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? * | ☐ | ☐ |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration? | ☐ | ☐ |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? * | ☐ | ☐ |
| 4) Are you currently charged with or have you been convicted of a forcible felony? * | ☐ | ☐ |

*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.

**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.

# VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

# VE-PC

1. NAME LAST FIRST MIDDLE

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

__ __ / __ __ / __ __ __ __
Month Day Year

5. SOCIAL SECURITY NUMBER

__ __ __ - __ __ - __ __ __ __

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

| | Profession Code |
|---|---|
| ☐ Permanent Physician License | 036 |
| ☐ Temporary Physician Training License | 125 |
| ☐ Chiropractic Physician License | 038 |

6. MAIDEN OR GIVEN SURNAME

**Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.**

A. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

C. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

F. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI):

SS#:

Profession:

**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

**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<br>__ __ / __ __ / __ __ __ __<br>Month Day Year | 3. SOCIAL SECURITY NUMBER<br>__ __ __ - __ __ - __ __ __ __ |
|---|---|---|
| 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.<br>_____ ___ ___ ___<br>Profession Name Profession Code | |
| 6. MAIDEN OR GIVEN SURNAME | 7. APPLICANT TELEPHONE NUMBER (Daytime)<br>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
Name of Licensing Agency or Board
Financial and Professional Regulation or its designated testing service, the information requested below.

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

☐ Examination (Administered in Your State)
- ☐ National (Name) _____
- ☐ State Constructed _____
- ☐ Other (Name) _____

☐ Endorsement of License (State) _____

Acceptance of Examination Results _____
(Administered in Another State)

☐ Reciprocity with (State) _____
☐ Waiver/Grandfather
☐ Credentials
☐ Other (Describe) _____
_____
_____

| F. CURRENT LICENSURE STATUS | G. IF LICENSED BY EXAMINATION, RECORD SCORES |
|---|---|
| ☐ Active<br>☐ Inactive<br>☐ Lapsed<br>☐ Other (Explain) _____<br>_____<br>_____ | Type of Examination Score<br>Written _____<br>Practical _____<br>Other (Describe) _____<br>_____<br>Received no Grade Below _____<br>Examination Period _____ days _____ hours |

NAME (Last, First, MI):

SS#:

Profession:

**PART III -** CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination — Date of Examination _____

*(Record all available information)*

| | | | |
|---|---|---|---|
| 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.

SEAL

Print Name

Title

Agency/Board Street Address

City, State, ZIP Code

Signature

Date

Area Code ( )

Telephone Number

**Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.**

**Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.**

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 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 GRADUATION

**(Current Year Graduates of LCME and COCA-Accredited Programs Only)**

SUPPORTING DOCUMENT

# ED - MED

**APPLICANT:** ***Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.***

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

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date _____ Signature _____

**SCHOOL OFFICIAL:** Complete the bottom portion of this page and return **ALONG** with a current official medical school transcript. **DO NOT** certify this form more than **30 days** prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

B. DATES OF ATTENDANCE

Start: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

End: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

Degree: _____ MD _____ DO

C.

Applicant will complete all requirements for the medical degree as of __ __ / __ __ / __ __ __ __ (Month / Day / Year) and will graduate on __ __ / __ __ / __ __ __ __ (Month / Day / Year) .

***When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.***

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

Signature of School Official _____

SCHOOL

S E A L

Print Name of School Official _____

Title _____

Date _____

**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 EDUCATION NON-LCME ACCREDITED MEDICAL COLLEGE

SUPPORTING DOCUMENT

# ED- NON

**APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.**

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month Day Year)

3. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

☐ Permanent Physician 036

☐ Temporary Physician 125

4. SOCIAL SECURITY NUMBER __ __ __-__ __-__ __ __ __ OR CONTACT ID NUMBER FROM IDFPR ACKNOWLEDGEMENT LETTER __ __ __ __ __ __ __ __ __

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date _____ Signature of Applicant _____

**APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THE LINE.**

**DEAN OF MEDICAL SCHOOL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant or altered, the form <u>will not</u> be accepted. Complete dates in form of month/day/year are required where indicated.**

A. NAME OF MEDICAL SCHOOL ADDRESS CITY, STATE COUNTRY/PROVIDENCE

B. DATES OF ATTENDANCE - **EACH YEAR** MUST BE LISTED SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

**<u>1st year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**<u>2nd year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**<u>3rd year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**<u>4th year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**<u>5th year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**<u>6th year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**<u>7th year</u>**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

INTERNSHIP YEAR, IF APPLICABLE
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

C. BASIC SCIENCE COURSES

**Anatomy**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**Physiology**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**Biochemistry**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**Microbiology/Immunology**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**Pathology**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**Pharmacology/Therapeutics**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

**Preventative Medicine**
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

D. INDICATE LENGTH OF ACADEMIC YEAR _____ MONTHS. DATE MEDICAL DEGREE WAS CONFERRED __ __ / __ __ / __ __ __ __ (Month Day Year)

NAME (Last, First, MI):

SS#:

Profession:

E. CORE CLERKSHIP ROTATIONS.

COMPLETE DATES IN THE FORM OF MONTH/DAY/YEAR ARE REQUIRED. EACH ROTATION MUST BE A MINIMUM OF FOUR (4) WEEKS IN LENGTH AND COMPLETED WHILE ENROLLED IN THE MEDICAL COLLEGE CONFERRING DEGREE. CORE ROTATIONS WILL NOT BE ACCEPTED OR CO-VALIDATED FROM ANOTHER MEDICAL SCHOOL. (MPA Section 11 (A)(2).)

**Internal Medicine Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Pediatrics Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Obstetrics/Gynecology Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Surgery Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Psychiatry Rotation****
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

** The 4 week psychiatry core clerkship rotation may be completed as follows: 2 weeks must be completed formally and distinctly in psychiatry as verified by the medical school on this form. The other 2 weeks may be completed in other clinical rotations as verified by the applicant's affidavit. Contact the Division for the *Affidavit of Psychiatry Core Clerkship Rotations* form.

I hereby certify that the information above is true and accurate to the records of this medical college and in accordance with Section 11 (A)(2) of the Medical Practice Act and Section 1285.20 of the Administrative Rules. I further certify that the applicant received a medical degree from and was enrolled in this college at the time the core rotations were completed; that the core clinical clerkship rotations were conducted in the clinical teaching facilities either **owned or operated by this medical college; government owned or operated;** OR **formally affiliated or contracted;** OR **held a verbal affiliation agreement** with this medical college. In the case of a written agreement, it is certified that all affiliation agreements were in full effect at the time of the applicant's rotation and evaluations verifying passage of each core clerkship rotation were submitted by the supervising physician.

SEAL OF COLLEGE

_____
Signature of Dean of Medical College

_____
Print Name of Dean of Medical College

_____
Date Completed

_____
Printed Name of Medical College

**RETURN THIS FORM TO APPLICANT**

**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.

# CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

# CA-MED

**NOTE: An applicant shall not commence 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 the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.**

| 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* | _____ Profession Name | __ __ __ Profession Code |

**ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.**

| A. *HOSPITAL/INSTITUTION NAME* | B. *BEGINNING DATE* __ __ / __ __ / __ __ __ __ Month Day Year | C. *ENDING DATE* __ __ / __ __ / __ __ __ __ Month Day Year |
|---|---|---|
| D. *BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE* | E. *SPECIALTY / RESIDENCY NAME* | |
| F. BUSINESS TELEPHONE NUMBER Area Code ( __ __ __ ) __ __ __ — __ __ __ __ | G. *YEAR OF POSTGRADUATE TRAINING* | |

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

_____
Signature of Program Director

_____
Print Name of Program Director

*SEAL*

_____
Title

_____
Date