

# Transfer & Extension of Temporary License

Instructions, Fillable 4-Page Application & Supporting Documents

If you have any questions/concerns, contact Thi Tran, Rush GME Licensing Specialist  
Click [here](#) to visit the RUSH GME Licensing Content

## FILING INSTRUCTIONS FOR TRANSFER/EXTENSION TEMPORARY LICENSURE

### 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:

- 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 Specialty/Residency (This form must be signed by the residency program director);
- f. A letter from the residency program director advising why a transfer is being requested;
- g. Fee: \$20.00;

### 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:

- 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: \$100.00, if extending beyond the initial 3 years;  
\$20.00, if extending within the initial 3 years;

**\*\*\*The dates on the CA-MED form should be the dates the applicant will be in training for the new program that they are transferring to, or the dates of the extension. Do not put your initial start date of the program. \*\*\***

## **REFERENCE SHEET**

<b><u>PROFESSION NAME</u></b>	<b><u>PROFESSION CODE</u></b>	<b><u>LICENSURE METHOD</u></b>
Temporary Physician Licensure	125	Nonexamination
Temporary Physician Transfer	125	Nonexamination
Temporary Physician Extension/Reissue	125	Nonexamination
Limited Temporary Physician Licensure	130	Nonexamination
Limited Temporary Physician Transfer/Reissue	130	Nonexamination

# 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

- |  |   |
|--|---|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.   | <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, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.               |
| <input type="checkbox"/> Other: _____  |   |

**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 600 S. Paulina St. Suite 403 AAC Chicago, IL 60612 Cook		
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 ____ / ____ / ____ Month Day Year	10. AGE ____ <input type="checkbox"/> Female <input type="checkbox"/> Male
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) ____-____-____ Home: (____) ____-____-____ (Area Code) (Area Code) Fax: (____) ____-____-____ Fax: (____) ____-____-____ (Area Code) (Area Code)		12. <b>REQUIRED</b> E-MAIL ADDRESS

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 ☐ No2. NAME OF LAST PRELIMINARY SCHOOL  
ATTENDED3. LAST PRELIMINARY SCHOOL LOCATION  
(City and State)

4. DATE OF GRADUATION

\_\_\_\_ / \_\_\_\_  
Month Year5. COLLEGE OR UNIVERSITY **Circle number of years completed****1 2 3 4 5 6 7 8**

Graduated?

☐ Yes ☐ No6. COLLEGE OR UNIVERSITY NAME  
(Undergraduate and Graduate)LOCATION  
(City and State or Country)

DATES OF ATTENDANCE

FROM

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

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.)

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. <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>			
<b>PART VII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)</b>			
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. <b>Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.</b>  Are you more than 30 days delinquent in complying with a child support order? Yes <input type="checkbox"/> No <input type="checkbox"/> (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 <input type="checkbox"/> No <input type="checkbox"/>			
<b>PART VIII: Certifying Statement</b>			
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.  <div style="display: flex; justify-content: space-between;"><div>_____ Signature of Applicant</div><div style="text-align: center;"></div><div>_____ Date</div></div> <b>I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.</b> 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.			

<b>IMPORTANT NOTICE:</b> 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.	<b>CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM</b>	SUPPORTING DOCUMENT  <b>CA-MED</b>
<b>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.</b>		
<b>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.</b>		
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.  <div style="display: flex; justify-content: space-between;"> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Profession Name</span> <span>Profession Code</span> </div>	
6. MAIDEN OR GIVEN SURNAME		
<b>ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.</b>		
A. HOSPITAL/INSTITUTION NAME  Rush University Medical Center	B. BEGINNING DATE  ____ / ____ / ____ Month      Day      Year	C. ENDING DATE  ____ / ____ / ____ Month      Day      Year
D. BUSINESS ADDRESS    STREET, CITY, STATE, ZIP CODE  600 S. Paulina St., 403 AAC, Chicago, IL. 60612	E. SPECIALTY/RESIDENCY NAME	
F. BUSINESS TELEPHONE NUMBER  Area Code ( <u>  3  </u> <u>  1  </u> <u>  2  </u> ) <u>  9  </u> <u>  4  </u> <u>  2  </u> — <u>  0  </u> <u>  3  </u> <u>  1  </u> <u>  2  </u>	G. YEAR OF POSTGRADUATE TRAINING  PGY -	
<p>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.</p> <div style="display: flex; justify-content: space-between; align-items: flex-end; margin-top: 100px;"> <div style="width: 45%;"> <p style="text-align: center; font-size: 1.2em; margin-top: 100px;">S E A L</p> </div> <div style="width: 50%; text-align: center;"> <div style="border-top: 1px solid black; margin-bottom: 10px;">Signature of Program Director</div> <div style="border-top: 1px solid black; margin-bottom: 10px;">Print Name of Program Director</div> <div style="border-top: 1px solid black; margin-bottom: 10px;">Title</div> <div style="border-top: 1px solid black;">Date</div> </div> </div>		



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? <i>If yes, attach a separate sheet with complete and accurate explanation.</i>		
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. <i>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.</i>		
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. <i>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.</i>		
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? <i>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.</i>		
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. <i>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.</i>		

## 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

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

