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

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