IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60 et. seq. (Illinois Compiled Statues). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

RETURN APPLICATION TO:
STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
ATTN: Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

Out-of-State Medical And Chiropractic Physicians Continuing Medical Education Approval

INSTRUCTIONS

This application MUST be submitted prior to participation in the program or within 90 days prior to expiration of the license.

A separate application must be submitted for **each** program for which you are seeking approval. This form may be duplicated. *Please print or type in BLACK ink only.*

If not submitted within the required time frame, late approval may be obtained by submitting a $25 processing fee plus a $100 per hour late fee, not to exceed $500.

Submit the following with this form:

1. A $25 fee made payable to the Illinois Department of Financial and Professional Regulation.
2. An outline of the content of the program.
3. A schedule of the program.
4. A brief biography or vitae of the instructor(s).
5. A copy of the certificate of attendance.

1. OFFICIAL NAME OF SPONSORING ORGANIZATION OR INSTITUTION	2. TELEPHONE NUMBER (Include Area Code)	
3. ADDRESS OF ORGANIZATION OR INSTITUTION (Include Street, City, State, and ZIP Code)	4. NAME OF PERSON RESPONSIBLE FOR C.M.E. PROGRAM	
5. TITLE OF PROGRAM	6. NUMBER OF CLOCK HOURS REQUESTED	7. IS THIS PROGRAM OPEN TO ALL MEDICAL AND CHIROPRACTIC PHYSICIANS?

8. SITE(S) OF PROGRAM	9. DATE(S) ATTENDED

10. HOW DOES THIS PROGRAM CONTRIBUTE TO THE PROFESSIONAL SKILLS AND KNOWLEDGE OF PHYSICIANS IN THE PRACTICE OF MEDICINE?

Signature of Person Submitting Application

Type or Print Name of Person Submitting Application

Illinois License Number

Print Mailing Address of Person Submitting Application

Date

City, State, ZIP Code

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.

OFFICIAL USE ONLY

☐ Approved (No. of Hours: _____) ☐ Denied ☐ Deferred

COMMENTS: _____

_____ Date: _____

IL486-1848 12/04 (MD)

PRINT RESET