PLEASE TYPE OR PRINT IN BLACK INK ONLY.

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.

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

AFFIDAVIT OF PSYCHIATRY CORE CLERKSHIP ROTATIONS

APPLICANT: This form is to be utilized to verify 2-weeks of psychiatry during another clinical rotation when the medical college has certified to completion of 2-weeks formally and distinctly of a **psychiatry rotation**. Form must be notarized.

1. NAME LAST FIRST MIDDLE

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

4. SOCIAL SECURITY NUMBER __ __ __ – __ __ – __ __ __ __

OR CONTACT ID NUMBER FROM IDFPR ACKNOWLEDGEMENT LETTER __ __ __ __ __ __ __ __ __

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

☐ Permanent Physician 036
☐ Temporary Physician 125

AFFIDAVIT OF PSYCHIATRY CORE CLERKSHIP ROTATIONS

This is to certify that while enrolled in medical college, I completed four (4) weeks of psychiatry core clerkship rotations. I further certify that of the four (4) weeks completed, at least two (2) of the four (4) weeks were obtained solely and distinctly in psychiatry; and the other two (2) week requirement was included and completed in other clinical rotations and did not overlap with the four (4) week requirement in said other required rotations.

The additional two (2) weeks were completed in the following other clinical rotation(s):

Rotation(s) _____ _____

Location(s) _____ _____

Dates of Rotation(s) _____ _____

CERTIFYING STATEMENT OF AFFIANT

Under penalties of perjury, I declare that the information I have recorded herein is true and correct.

_____

Signature of Affiant

SUBSCRIBED AND SWORN TO me, this _____ day of _____ , 20___ .

_____

NOTARY PUBLIC STATE OF ILLINOIS COUNTY OF _____