IDFPR
Illinois Department of Financial and Professional Regulation
Division of Professional Regulation

APPLICATION FOR:
VISITING RESIDENT EXEMPTION FORM - VISITING ROTATIONS

Important Information:

- We recommend that you review the guidance for Visiting Resident Exemption prior to applying, which can be found at ***https://www.idfpr.illinois.gov/profs/physicians.html***.
- A person may participate in visiting rotations in an approved postgraduate training program, not to exceed a total of 90 days for all rotations, if the following information is submitted to the Department by the patient care clinics or facilities where the person will be performing the training or by an affiliated program:

  (1) The person who has been invited or appointed to perform a portion of their postgraduate clinical training program in Illinois.

  (2) The name and address of the primary patient care clinic or facility, the date the training is to begin, and the length of time of the invitation or appointment.

  (3) The name and license number of the Illinois physician who will be responsible for supervising the trainee and the medical director or the division director of the department or facility.

  (4) Certification from the postgraduate training program that the person is approved and enrolled in a postgraduate training program approved by the Department in their home state.

OUT-OF-STATE PROGRAM INFORMATION

Postgraduate Training Program's Name: _____

Specialty: _____ Program Director's Name: _____

Street Address: _____ City: _____

State: _____ Zip code: _____ Contact's Name: _____

Contact's Email: _____ Contact's Phone #: _____

TRAINEE INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Last 4 of SSN: _____ or TIN: _____

Email: _____ Daytime Phone Number: _____

Program Start Date: _____ Program End Date: _____

ILLINOIS CLINIC OR FACILITY INFORMATION

Name of Patient Care Clinic or Facility: _____

Street Address: _____ City: _____

State: _____ Zip code: _____ Contact's Name: _____

Contact's Email: _____ Contact's Phone #: _____

Name of Medical Director/Division Director of the Department or Facility: _____

Name of Illinois Physician Responsible for Supervising Trainee: _____

Illinois Physician License # of Physician Responsible for Supervising Trainee: _____

Rotation Name (Specialty): _____ Rotation Length: _____

Rotation Start Date: _____ Rotation End Date: _____

OUT-OF-STATE PROGRAM CERTIFICATION

I do hereby declare that I have examined this Form and that the above-named trainee is approved and enrolled in a postgraduate training program approved by the Department in their home state as indicated above.

Program Director's Signature: _____

Date: _____

ILLINOIS CLINIC OR FACILITY CERTIFICATION

I do hereby declare that I have examined this Form and that the above-named trainee has been invited or appointed to perform a portion of a postgraduate training program in Illinois as indicated above. I further hereby declare that I assume full supervisory responsibility for the trainee in Illinois during the period specified.

Signature of Illinois Physician Responsible for Supervision: _____

Date: _____

PLEASE EMAIL COMPLETED FORM TO THE ILLINOIS DIVISION OF PROFESSIONAL REGULATION AT: ***FPR.MEDICALUNIT@ILLINOIS.GOV***.

THE TRAINEE SHALL NOT COMMENCE THE APPOINTMENT BEFORE THE ILLINOIS CLINIC OR FACILITY RECEIVES WRITTEN NOTIFICATION FROM THE DIVISION OF THE APPROVAL OF THIS FORM. NOTIFICATION MAY BE MADE VIA EMAIL.