

# INSTRUCTION SHEET

## Physician--Visiting Professor Permit

***In order for your application to be processed,  
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED  
with the application and required fee unless otherwise directed in the instructions.***

Follow each of the steps in the order that they are listed on **both sides** of this Instruction Sheet. This will aid you in accurately completing your application and thus, eliminate any delay in processing. **IF APPROVED, THE INITIAL LICENSE IS VALID FOR 2 YEARS OR FOR THE TERM OF THE FACULTY APPOINTMENT IF LESS THAN 2 YEARS. The fee is not refundable.**

**Step I** Complete the four-page Application for Licensure/Examination as follows:

1. Part I-A, Application Category Information--Complete Part I-A as indicated below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Visiting Professor	113	Nonexamination	\$300.00

2. Part I-B--Check the box indicating the appropriate information regarding your application.
3. Part II--Applicant Identifying Information--Enter all applicable information requested.
4. Part III, Education Information
  - a. Numbers 1 through 5--Enter all applicable information requested.
  - b. Number 6--Indicate all post secondary education which you have attended since graduation from high school. Please indicate beginning and ending dates, by year.
  - c. Number 7--Indicate Specialty/Residency training.
5. Part IV, Record of Licensure Information--Individuals licensed in jurisdictions located both inside and outside the United States **MUST** indicate in this area whether or not they have ever held licensure, registration, or permit to practice as a physician.
6. Part V, Record of Examination--Indicate examination dates and results for any and all medical examinations taken (i.e., FLEX, National Board, USMLE, state constructed.)
7. Part VI, Personal History Information--This part must be completed by all applicants.
8. Part VII, Examination Coding Information--Indicate N/A in items a through e.
9. Part VIII, Child Support Information. This part must be completed by all applicants.
10. Part IX, Certifying Statement--Read the certifying statement and then sign and date your application.

**Step II**

The following documentation must be submitted with the four-page application. All documents submitted in a foreign language must be accompanied by an official, notarized translation that has been performed by a person, other than the applicant, who is fluent in both English and the language of the document(s). The translator shall certify to the above requirements as well as to the accuracy of the translation.

- a. **CT (Certification of Licensure)**--Complete the top half of the enclosed form. The rest of the form must be completed by the jurisdiction of original licensure. You must direct the licensing agency/board to return completed document CT directly to you.
- b. **MD-VPR (Certification of Contractual Agreement for Visiting Professor)**. Follow instructions given on the form.
- c. Copy of your **current Curriculum Vitae**.
- d. Supporting Document **VE-PRO** must be completed by the dean of a program of medicine located in another jurisdiction certifying that you were qualified and held professor status at said institution.

If you submit original or official documents that you want returned to you, you must also provide a photocopy of the document(s) and a self-addressed stamped envelope.

**Step III**

Application Fee - \$300

Fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation.

**Step IV**

Forward 4-page application, supporting documentation, and fee payment to:

Illinois Department of Financial and Professional Regulation  
Attn: Division of Professional Regulation  
P.O. Box 7007  
Springfield, Illinois 62791

**Step V**

If assistance is needed, direct your request to the following telephone number:

217-782-8556

When an operator answers, state the profession for which you are applying and that you need assistance with your application. Please allow 3 weeks from mailing your application before making an inquiry concerning its status.

## LICENSURE METHODS AND DEFINITIONS

*Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.*

### Licensure Methods

### Definition

Examination

Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department.

Endorsement of License

Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued.

Acceptance of Examination

Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.

Restoration

Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review.

Grandfather/Waiver

Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).

Non-examination

Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.

# IMPORTANT NOTICE

## Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966.**"

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"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse.**"

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Visiting Professor Permit

*In order for your application to be processed,  
**ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED**  
 with the application and required fee unless otherwise directed in the instructions.*

Before you mail your application, check the following items to make sure your application is complete!

FOUR-PAGE APPLICATION REVIEW	COMPLETED
Part I. Application Category Information	
Part II. Applicant Identifying Information	
Part III. Education Information	
Part IV. Record of Licensure Information	
Part V. Record of Examination	
Part VI. Personal History Information	
Part VII. Examination Coding Information (if applicable)	
Part VIII. Child Support and/or Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS	SUBMITTED
Application Fee	
CT (Certification of Licensure) Form from jurisdictions of current licensure	
Copy of curriculum vitae (CV)	
MD-VPR Form	
VE-PRO Form	

**All supporting documents may not be required. Please refer to application instructions for your specific method of licensure.**

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for double-sided printing.**

# APPLICATION FOR LICENSURE AND/OR EXAMINATION

**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. Check the box indicating the appropriate information regarding your application.  Military  Military Spouse  Not Military  Decline to Answer  
 Military service member is defined as: "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. 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 \$
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C. 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.<br><br><input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.<br><br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.<br><br><input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|---|--|

## 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
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: (____) _____ -- _____ Fax: (____) _____ -- _____ Fax: (____) _____ -- _____ (Area Code) (Area Code) (Area Code) (Area Code)		12. <b>REQUIRED</b> E-MAIL ADDRESS





**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>			

**PART VII: Examination Coding Information (This part is for examination applicants only)**

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) CHART III - Select the examination site you desire and enter Test Center Code:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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c) CHART IV - Find your School of Graduation and enter school code:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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d) Record the number of times you have taken this exam in Illinois or any other state:

<input type="text"/>	<input type="text"/>
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**PART VIII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)**

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. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

Are you more than 30 days delinquent in complying with a child support order? Yes  No   
 (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  No

**PART IX: Certifying Statement**

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.

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

**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.

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

## \* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

## \* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

**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.

**CERTIFICATION BY LICENSING AGENCY / BOARD**

SUPPORTING DOCUMENT

**CT**

**APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.**

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	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code ( ____ ) _____ - _____	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize \_\_\_\_\_ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.  
Name of Licensing Agency or Board

Signature \_\_\_\_\_ Date \_\_\_\_\_

**RETURN COMPLETED FORM TO APPLICANT**

**LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.**

**PART I - CERTIFICATION OF EXAMINATION STATUS**

A. The applicant  has written  is scheduled to write the following examination:  
 \_\_\_\_\_  
 Name of Examination Date of Examination

B. The applicant has or will have written the above-named examination \_\_\_\_\_ number of times.

**PART II - CERTIFICATION OF LICENSURE**

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

<input type="checkbox"/> Examination (Administered in Your State)	<input type="checkbox"/> Reciprocity with (State) _____
<input type="checkbox"/> National (Name) _____	<input type="checkbox"/> Waiver/Grandfather _____
<input type="checkbox"/> State Constructed _____	<input type="checkbox"/> Credentials _____
<input type="checkbox"/> Other (Name) _____	<input type="checkbox"/> Other (Describe) _____
<input type="checkbox"/> Endorsement of License (State) _____	
Acceptance of Examination Results _____	
(Administered in Another State)	

F. CURRENT LICENSURE STATUS	G. IF LICENSED BY EXAMINATION, RECORD SCORES
<input type="checkbox"/> Active	Type of Examination Score
<input type="checkbox"/> Inactive	Written _____
<input type="checkbox"/> Lapsed	Practical _____
<input type="checkbox"/> Other (Explain) _____	Other (Describe) _____
_____	Received no Grade Below _____
_____	Examination Period ____ days ____ hours

**PART III - CERTIFICATION OF EXAMINATION SCORES**

A1. National or other Profession Specific Examination  
(Record all available information)

Date of Examination \_\_\_\_\_

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

**PART IV - FORMAL ACTIONS**

- A. Is there now or has there ever been any formal action commenced against the applicant?  Yes  No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.)  Yes  No

**PART V - RECIPROCAL REGISTRATION**

This state  does  does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

SEAL

\_\_\_\_\_

Print Name

\_\_\_\_\_

Title

\_\_\_\_\_

Agency/Board Street Address

\_\_\_\_\_

City, State, ZIP Code

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

Area Code (     )

\_\_\_\_\_

Telephone Number

**Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.**

**Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.**

NAME (Last, First, MI):

SS#:

Profession:



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.

## VERIFICATION OF PROFESSOR STATUS

SUPPORTING DOCUMENT

# VE-PRO

**APPLICANT: Complete the applicant section of this form. Forward the form to the Dean of the School at which you held professor status. Return the completed form with the Application for Licensure/ Examination.**

1. NAME LAST                      FIRST                      MIDDLE	2. DATE OF BIRTH ____ / ____ / ____ Month      Day                      Year	3. SOCIAL SECURITY NUMBER ____ - ____ - ____
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. PROFESSION NAME AND CODE.  <b>Visiting Professor Physician</b> _____ Profession Name                      Profession Code	
6. MAIDEN OR GIVEN SURNAME		

**DEAN OF MEDICAL SCHOOL: Complete the remainder of this form. Return the completed form to the applicant.**

A. NAME OF MEDICAL PROGRAM (Medical, Osteopathic, or Chiropractic College)

B. LOCATION OF MEDICAL PROGRAM (Street, City, State, ZIP Code)

I hereby certify that \_\_\_\_\_

held professor status at this institution from \_\_\_\_\_ to \_\_\_\_\_.

I do hereby declare that this information is true and correct.

SEAL

\_\_\_\_\_  
Signature of Dean

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Dean

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for double-sided printing.**

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 CONTRACTUAL AGREEMENT FOR  
VISITING PROFESSOR**

SUPPORTING DOCUMENT

**MD-VPR**

**NOTE:** *An applicant shall not commence a faculty appointment before the program director receives written notification of application approval from the Department of Financial and Professional Regulation.*

*The initial Visiting Professor Permit shall be valid for 2 years or for the term of the faculty appointment if less than 2 years. The applicant may be required to appear before the Board for an interview prior to the issuance of the original permit.*

**APPLICANT:** *Complete the applicant section of this form. Forward the form to the Dean of the School at which the contract has been established. Return the completed form with the Application for Licensure/ Examination at least 60 days prior to the beginning date of the faculty appointment.*

1. NAME LAST                      FIRST                      MIDDLE	2. DATE OF BIRTH ____/____/____ Month    Day    Year	3. SOCIAL SECURITY NUMBER ____-____-____
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. PROFESSION NAME AND CODE.  <b>Visiting Professor Physician</b> _____ Profession Name                      Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. TYPE OF PERMIT [ ] Original [ ] Renewal	8. IF RENEWAL, RECORD ORIGINAL PERMIT NUMBER

**DEAN OF SCHOOL:** *Complete the remainder of this form, then return the form to the applicant.*

A. NAME OF SCHOOL (Medical, Osteopathic, or Chiropractic School)	B. DEPARTMENT NAME
C. LOCATION OF SCHOOL (Street, City, State, Zip Code)	D. TELEPHONE NUMBER (Include Area Code)
E. DATES OF APPOINTMENT From ____/____/____ To ____/____/____ Month    Day    Year                      Month    Day    Year	F. FAX NUMBER (Include Area Code)

G. DESCRIBE NATURE OF EDUCATIONAL SERVICE TO BE PROVIDED BY THE APPLICANT AND QUALIFICATION OF APPLICANT

**COMPLETE REVERSE SIDE**

H. RECORD THE NEED FOR THE SERVICE TO BE PROVIDED BY THE APPLICANT

NAME (Last, First, MI):

I. NAME AND ADDRESS OF THE PATIENT CARE CLINICS OR FACILITIES AFFILIATED WITH THE MEDICAL PROGRAM AT WHICH THE APPLICANT WILL BE PROVIDING INSTRUCTION AND/OR PROVIDING CLINICAL CARE AND A JUSTIFICATION FOR ANY CLINICAL ACTIVITIES THAT WILL BE PROVIDED AT THE FACILITIES.

NAME OF CLINIC OR FACILITY	ADDRESS	JUSTIFICATION

SS#:

Profession:

I do hereby declare that the above-named applicant has entered into a contractual agreement as a visiting professor with the above-stated contract terms.

SEAL

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Dean

\_\_\_\_\_ Print or Type Name of Dean