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 EDUCATION

APPLICANT: This form is to be utilized when attempts to obtain the required Certification of Education (form ED-NON) have been unsuccessful. Proof of your attempts to secure the ED-NON form must be submitted with the completed affidavit. Form must be notarized. **DO NOT COMPLETE THIS FORM UNLESS INSTRUCTED BY IDFPR.**

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

I, _____, under oath do solemnly swear under penalties of perjury that the following statements and information, to the best of my knowledge, are true, correct and complete.

1. THAT, due to _____, I am unable to obtain documentation from my medical college to verify that I meet the minimum education standards described in Section 11 (A) (2) of the Illinois Medical Practice Act of 1987 [225 ILCS 60].

2. THAT, I graduated from a medical or osteopathic college which is officially recognized by the jurisdiction in which it is located for the purpose of receiving a license to practice medicine in all of its branches.

3. THAT, I completed at least two (2) academic years of study in the basic medical sciences while enrolled in the medical college that conferred my degree which included formal instruction in the following subjects:

BASIC SCIENCE COURSES

Anatomy
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Pathology
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Physiology
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Pharmacology/Therapeutics
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Biochemistry
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Preventative Medicine
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Microbiology/Immunology
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

4. THAT, I completed at least two (2) academic years of study in the clinical sciences while enrolled in the medical college that conferred my degree which included at least four (4) weeks in the following required core clerkship rotations:

CORE CLERKSHIP ROTATIONS

Internal Medicine Rotation

Started:____/____/____ Completed:____/____/____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____

Pediatrics Rotation

Started:____/____/____ Completed:____/____/____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____

Obstetrics/Gynecology Rotation

Started:____/____/____ Completed:____/____/____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____

Surgery Rotation

Started:____/____/____ Completed:____/____/____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____

Psychiatry Rotation

Started:____/____/____ Completed:____/____/____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____

5. THAT, I received a medical degree from and was enrolled in this medical college at the time the core rotations were completed. I further certify that the core clinical clerkship rotations were conducted in clinical teaching facilities either owned or operated by the medical college; government owned or operated; OR formally affiliated or contracted; OR held a verbal affiliation agreement with the medical college. I successfully completed each core rotation.

6. THAT, the above stated information is true and accurate to the best of my knowledge and in accordance with Section 11 (A) (2) of the Illinois Medical Practice Act and Section 1285.20 of the Administrative Rules.

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 _____