INSTRUCTIONS

FOR MAKING APPLICATION UNDER PROVISIONS OF THE

ILLINOIS OPTOMETRIC ACT

Acceptance of Examination
Endorsement
Restoration

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 COMPLETING THE APPLICATION PACKAGE, read each of the 4 steps below in the order that they are listed, then follow the directions as they apply to you. This will aid you in completing your application accurately and eliminate any delay in processing. THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT. If you are issued a license, please be advised that your license will expire March 31st of each even-numbered year.

Step 1. Use the **REFERENCE SHEET (CHART I)** to select the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee, and record that information in **PART I** (page one) of the **Application for Licensure and/or Examination**.

Step 2. Proceed with **PART II** (page one) and complete all applicable information requested on all 4 pages of the **Application for Licensure and/or Examination**.

Step 3. The remainder of this form contains specific instructions for each Licensure Method. Locate the instructions for the Licensure Method you recorded on **PART I** (page one), of the **Application for Licensure and/or Examination** and follow those instructions only.

NOTE: All documents in a foreign language that are required to be submitted with an application or for any other purpose in connection with licensure must be accompanied by an original, 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.

Step 4. If needed, telephone numbers for assistance in completing the Application Package are provided on the **REFERENCE SHEET**.

Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Phamaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.

ACCEPTANCE OF EXAMINATION

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.

NOTE: Complete and return this application and all supporting documents and instruct the National Board of Examiners in Optometry (N.B.E.O.) to forward your scores directly to the Department when you have successfully completed all parts of the National Board including passage of the Treatment and Management of Ocular Disease (T.M.O.D.).

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Supporting Document **ED** must be completed by the dean or registrar of the optometry education program attended with the school seal affixed. Must be submitted with each application.

3. Supporting Document **TN-D-OPT ;TN-T-OPT and TN-T-ORALS must** be completed if you graduated from an approved school of Optometry before January 1, 1984.

4. Supporting Document **TN-D-OPT and TN-T-ORALS must** be completed if you graduated from an approved school of Optometry from January 1, 1984 thru December 31, 1993.

5. Supporting Document **TN-T-ORALS must** be completed if you graduated from an approved school of Optometry from January 1, 1994 thru December 31, 2007.

6. If you graduated January 1, 2008 and forward, only Supporting Document **ED** is required.

7. If you have ever been licensed as an optometrist, Supporting Document **CT** must be completed by the jurisdiction of the original licensure and current licensure which you have been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** directly to you.

8. A certified copy of your National Board of Examiners in Optometry (NBEO) score must be sent directly to this Division from NBEO indicating that you passed both parts of the written theoretical examination, including TMOD, and the clinical skills examination.

9. Fee payment is indicated on the **REFERENCE SHEET, CHART I**. Fee payment must be in the form of a check or money order made payable to Department of Financial and Professional Regulation.

10. Forward four-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P.O. 7007, Springfield, Illinois 62791.

Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Phamaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.

ENDORSEMENT

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.

NOTE: Based on the Illinois Optometric Licensing and Disciplinary Board evaluation of your application and supporting documents, you may be required to submit additional documentation. Your application evaluation is based upon the equivalency of your examination results in the previous jurisdiction compared to the Illinois examination administered the same year.

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Supporting Document **ED** must be completed by the dean or registrar of the optometry education program attended with the school seal affixed. Must be submitted with each application.

3. Supporting Document **TN-D-OPT ;TN-T-OPT and TN-T-ORALS must** be completed if you graduated from an approved school of Optometry before January 1, 1984.

4. Supporting Document **TN-D-OPT and TN-T-ORALS must** be completed if you graduated from an approved school of Optometry from January 1, 1984 thru December 31, 1993.

5. Supporting Document **TN-T-ORALS must** be completed if you graduated from an approved school of Optometry from January 1, 1994 thru December 31, 2007.

6. If you graduated January 1, 2008 and forward, only Supporting Document **ED** is required.

7. If you have ever been licensed as an optometrist, Supporting Document **CT** must be completed by the jurisdiction of the original licensure and current licensure which you have been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** directly to you.

8. A certified copy of your National Board of Examiners in Optometry (NBEO) score must be sent directly to this Division from NBEO indicating that you passed both parts of the written theoretical examination, including TMOD, and the clinical skills examination.

9. Submit a copy of the licensing Acts and Rules for registration in the jurisdiction of original licensure for the time you were licensed.

10. Fee payment is indicated on the **REFERENCE SHEET, CHART I**. Fee payment must be in the form of a check or money order made payable to Department of Financial and Professional Regulation.

11. Forward four-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P.O. 7007, Springfield, Illinois 62791.

Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Phamaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.

OPTOMETRY RESTORATION

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.

IMPORTANT NOTICE: These Restoration Instructions apply only to those optometrists whose licenses have been on inactive status, or in non-renewed status, for three or more years.

If your license has been inactive, or in non-renewed status, for less than three years, you should contact the Department of Financial and Professional Regulation Call Center at 1-800-560-6420 for detailed instructions on how to restore it to active status.

NOTE: Based on the Illinois Optometric Licensing and Disciplinary Board evaluation of your application and supporting documents, you may be required to submit additional documentation.

1. Supporting Document CCA **must** be completed. If this form was not included in the application packet, they must obtain one by contacting the DPR Call Center at 1-800-560-6420.

2. Supporting Document **RS** must be completed by each state in which you have ever been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** directly to the address indicated in number 9 below.

3. Submit one of the following documents:
   a) Supporting Document **CT** must be completed by the jurisdiction of original licensure and current licensure in which they have been issued a license. You are authorized to photocopy the form if necessary. You may direct the licensing agency/board to return the completed form **CT** directly to you.
   AND
   Supporting Document **VE** must be completed by your employer to verify current active practice in another jurisdiction. If self-employed, complete the document on your own behalf. If this form is not included in the application packet, the applicant must obtain one by contacting the Division of Professional Regulation at 1-800-560-6420. **OR**
   b) If restoring after active military service, submit a copy of DD214.

4. If unable to submit supporting documents **VE** or form DD214, proof of completion of one of the following must be submitted:
   a) Evidence of other education or other experience acceptable to the Division of the licensee's fitness to have the certification restored. Such evidence shall be reviewed on a case by case basis by the Board;
   OR
   b) Certification of passage of Part III of the examination administered by the NBEO.

5. Submit the following documents:
   a) Evidence of an existing Therapeutic Pharmaceutical agent certification at the time license was placed in inactive or expired status; **AND**
   b) Proof of completion of the Oral Pharmaceutical Agents requirement pursuant to Section 1320.335 of the Rules.

6. All applicants for Restoration of optometry license in Illinois must submit proof of having met the 30-hour requirement of continuing education during the 2 years prior to restoration. This must be verified by submission of certificates of attendance provided by approved sponsors of continuing education programs.

7. Proof of current certification in cardiopulmonary resuscitation (CPR).

8. Fee payment amount is indicated in the Official Use Only Box on Supporting Document **RS**. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.

9. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P.O. 7007, Springfield, Illinois 62791.

Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Phamaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.

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."**

"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."**

REFERENCE SHEET

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change fees if prevailing circumstances necessitate such action.

CHART I - PROFESSION NAME, PROFESSION CODE, LICENSURE METHOD & FEE

PROFESSION NAME	PROFESSION CODE	LICENSURE METHOD	APPLICATION FEE
Registered Optometrist	046	Acceptance of Examination	$500.00
Registered Optometrist	046	Endorsement	$500.00
Registered Optometrist	046	Restoration	See Supporting Document **RS**

CHART II - EXAMINATION CODES AND FEES

NOT APPLICABLE FOR OPTOMETRIST
ENTER N/A IN PART VII a) OF
APPLICATION FOR LICENSURE AND/OR EXAMINATION

CHART III - EXAMINATION DATES AND LOCATION

NOT APPLICABLE FOR OPTOMETRIST
ENTER N/A IN PART VII b) OF
APPLICATION FOR LICENSURE AND/OR EXAMINATION

CHART IV - SCHOOL CODES

NOT APPLICABLE FOR OPTOMETRIST
ENTER N/A IN PART VII c) OF
APPLICATION FOR LICENSURE AND/OR EXAMINATION

* * * * * REQUEST FOR ASSISTANCE * * * * *

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

DPR Call Center - 1-800-560-6420

TTY - 1-866-325-4949

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Optometry

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	
CCA Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.	
CT (Certification of Licensure) Form completed by **each** jurisdiction of licensure	
ED Form completed by school showing graduation from an approved Optometric program	
TN-D-OPT (if applicable)	
TN-T-OPT (120 hours) (if applicable)	
TN-T-Orals (Orals) (if applicable)	
C.E. (18 approved regular hours and 12 approved TQ hours) (if applicable)	
Copy of **DD214** if restoring license from active military service	
RS (Restoration) Form--Form is required if restoring an expired or inactive license (complete all applicable sections)	
VE (if applicable)	
CT Form; or **DD214;** or proof of examination or education program	

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

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
	___ ___ ___		$

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☐ This is the first time I have made application for this profession in Illinois.

☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

☐ Other: _____

☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

☐ 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	10. AGE
	__ __ / __ __ / __ __ __ __ Month Day Year	____ ☐ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. **REQUIRED** E-MAIL ADDRESS
Work: (__ __ __) __ __ __ -- __ __ __ __ (Area Code) Home: (__ __ __) __ __ __ - __ __ __ __ (Area Code) Fax: (__ __ __) __ __ __ - __ __ __ __ (Area Code) Fax: (__ __ __) __ __ __ -- __ __ __ __ (Area Code)	

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12 Graduated High School? ☐ Yes ☐ No OR Received G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION ___ ___ / ___ ___ ___ ___ Month Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8 Graduated? ☐ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE		TYPE OF DEGREE EARNED
		FROM	TO	
		Month/Year	Month/Year	

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM	TO	
		Month/Year	Month/Year	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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.)

NAME (Last, First, MI):

SS#:

Profession:

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. *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.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
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? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
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? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

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

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

c) CHART IV - Find your School of Graduation and enter school code:

d) Record the number of times you have taken this exam in Illinois or any other state:

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.

NAME (Last, First, MI):

SS#:

Profession:

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.**

- ☐ Acupuncturists
- ☐ Advanced Practice Registered Nurses
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Medication Aide
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

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? *	☐	☐
2)	Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☐
3)	Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☐
4)	Are you currently charged with or have you been convicted of a forcible felony? *	☐	☐

*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.

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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
Name of Licensing Agency or Board
Financial and Professional Regulation or its designated testing service, the information requested below.

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

- ☐ Examination (Administered in Your State)
  - ☐ National (Name) _____
  - ☐ State Constructed _____
  - ☐ Other (Name) _____
- ☐ Endorsement of License (State) _____
- Acceptance of Examination Results _____ (Administered in Another State)
- ☐ Reciprocity with (State) _____
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) _____

F. CURRENT LICENSURE STATUS

- ☐ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	_____
Practical	_____
Other (Describe) _____	
Received no Grade Below	_____

Examination Period _____ days _____ hours

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination — Date of Examination _____

(Record all available information)

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 _____ Signature _____

Agency/Board Street Address _____ Date _____

City, State, ZIP Code _____ 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 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATION OF EDUCATION**	SUPPORTING DOCUMENT **ED**

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

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.	
6. MAIDEN OR GIVEN SURNAME	_____ Profession Name	___ ___ ___ Profession Code
7. NAME OF INSTITUTION ATTENDED	8. DATE OF GRADUATION / COMPLETION __ __ / __ __ / __ __ __ __ Month Day Year	

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

_____ Date

_____ Signature of Applicant

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. NAME OF INSTITUTION	B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
C. DEPARTMENT OF INSTITUTION	D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT
E. MAJOR AREA OF STUDY OF THE APPLICANT	F. APPLICANT WAS (CHECK ONE): ☐ Full-time ☐ Part-time ☐ Co-op
G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) ☐ _____ Semester Hours ☐ _____ Quarter Hours ☐ _____ Course Hours	H. DATES OF ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year
I. Total academic years attended _____ Years _____ Months _____ Days **OR** Total calendar years attended _____ Years _____ Months _____ Days	J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)
K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET __ __ / __ __ / __ __ __ __ Month Day Year	L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED __ __ / __ __ / __ __ __ __ Month Day Year

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

☐ Applicant has graduated on __ __ / __ __ / __ __ __ __ Month Day Year

☐ Applicant has completed program on __ __ / __ __ / __ __ __ __ Month Day Year

☐ Applicant will graduate on __ __ / __ __ / __ __ __ __ Month Day Year

☐ Applicant will complete program on __ __ / __ __ / __ __ __ __ Month Day Year

N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____ , 20____.

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

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.	**VERIFICATION OF EMPLOYMENT / EXPERIENCE**	SUPPORTING DOCUMENT **VE**

APPLICANT: ***Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. 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. JOB TITLE OR POSITION APPLICANT HELD	
8. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ Month Day Year To __ __ /__ __ /__ __ __ __ Month Day Year	9. SUPERVISOR NAME	

EMPLOYER: ***Complete the remainder of this form. Return the completed form to the applicant in a sealed envelope.***

PART I - EMPLOYMENT INFORMATION

A. EMPLOYER NAME		B. BUSINESS / INSTITUTION NAME
C. EMPLOYER REGISTRATION/LICENSE NUMBER	D. STATE OF EMPLOYER REGISTRATION/LICENSE	E. BUSINESS ADDRESS STREET CITY STATE ZIP CODE
F. BUSINESS REGISTRATION/LICENSE NUMBER (If Applicable)	G. STATE OF BUSINESS REGISTRATION/LICENSE	H. BUSINESS TELEPHONE NUMBER Area Code (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

PART II - APPLICANT EMPLOYMENT INFORMATION

A. NUMBER OF HOURS WORKED PER WEEK	B. TYPE OF EMPLOYMENT [ ]Full-time [ ]Part-time	C. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ Month Day Year To __ __ /__ __ /__ __ __ __ Month Day Year
D. RECORD APPLICANT'S POSITION TITLE(S)		
E. GIVE BRIEF DESCRIPTION OF DUTIES PERFORMED BY THE APPLICANT.		

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

_____ Signature

_____ Date

_____ Title

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 80 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 DIAGNOSTIC TRAINING

SUPPORTING DOCUMENT

TN-D-OPT

APPLICANT: Complete the applicant section of this form. Forward form to the individual who will certify your training.

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.

OPTOMETRY (Profession Name) — 0 4 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

7. DATES OF TRAINING

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

8. COURSE TITLE / INSTITUTION

CERTIFYING OFFICIAL: Complete the remainder of this form. RETURN THE COMPLETED APPLICATION TO THE APPLICANT.

A. CERTIFYING OFFICIAL

B. INSTITUTION NAME

C. INSTRUCTOR JOB TITLE/PROFESSION NAME

D. INSTITUTION STREET ADDRESS

E. INSTITUTION TELEPHONE NUMBER

Area Code (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

F. INSTITUTION CITY, STATE, ZIP CODE

G. APPLICANT'S TRAINING DATES

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

H. TRAINING CLOCK HOURS APPLICANT

I. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?

☐ Yes ☐ No

J. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTION FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED.

K. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING.

NAME (Last, First, MI):

SS#:

Profession:

I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official

Signature of School Official and/or Director/Administrator of Training Programs

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____ , 20____.

Date of Expiration

Signature of Notary Public

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 80 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 ORAL THERAPEUTIC TRAINING

SUPPORTING DOCUMENT

TN-T-ORALS

APPLICANT: ***Complete the applicant section of this form. Forward the form to the individual who will certify your training. This form must be completed for individuals graduating after January 1, 1994.***

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.

OPTOMETRY (Profession Name) **0 4 6** (Profession Code)

6. MAIDEN OR GIVEN SURNAME

7. DATES OF TRAINING

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

8. COURSE TITLE / INSTITUTION

CERTIFYING OFFICIAL: ***Complete the remainder of this form. RETURN COMPLETED FORM TO APPLICANT.***

A. CERTIFYING OFFICIAL

B. INSTITUTION NAME

C. INSTRUCTOR JOB TITLE/PROFESSION NAME

D. INSTITUTION STREET ADDRESS

E. INSTITUTION TELEPHONE NUMBER

Area Code (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

F. INSTITUTION CITY, STATE, ZIP CODE

G. APPLICANT'S TRAINING DATES

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

H. TRAINING CLOCK HOURS APPLICANT

I. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?

☐ Yes ☐ No

J. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTION FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED.

I certify that this applicant for Illinois licensure has successfully completed 30 hours of therapeutic ocular training in systemic disease. The subject areas were:

		Name of Instructor
a.	Cardiovascular	_____
b.	Respiratory Disorders (e.g. Pulmonary)	_____
c.	Immunology	_____
d.	Infectious Disease	_____
e.	Dermatology	_____
f.	Cataract Surgery - 2 hours maximum	_____
g.	General Medical Emergency	_____
h.	Endocrinology	_____
i.	Collagen Vascular Disease	_____

I certify that the information recorded herein is true and correct according to the official records of this institution.

_____ Print Name of School Official

_____ Signature of Chief Academic Officer

_____ Title

_____ Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____ , 20____.

_____ Date of Expiration

_____ Signature of Notary Public

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 80 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 120 HOURS OF THERAPEUTIC TRAINING

SUPPORTING DOCUMENT

TN-T-OPT 120 Hours

APPLICANT: Complete the applicant section of this form. Forward form to the individual who will certify your training. Training must have been obtained after January 1, 1994.

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.

OPTOMETRY (Profession Name) — 0 4 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

7. DATES OF TRAINING

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

8. COURSE TITLE / INSTITUTION

CERTIFYING OFFICIAL: Complete the remainder of this form. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. CERTIFYING OFFICIAL

B. INSTITUTION NAME

C. INSTRUCTOR JOB TITLE/PROFESSION NAME

D. INSTITUTION STREET ADDRESS

E. INSTITUTION TELEPHONE NUMBER

Area Code (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

F. INSTITUTION CITY, STATE, ZIP CODE

G. APPLICANT'S TRAINING DATES

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

H. TRAINING CLOCK HOURS APPLICANT

I. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?

☐ Yes ☐ No

J. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTION FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED.

K. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING.

I. At least 60 hours taught by faculty members of the college or university sponsoring the course in the following subject areas:

1. Anatomy and Physiology Considerations in Ocular Disease - 5 hours minimum
2. Pharmacology of Therapeutic Agents - 10 hours minimum
3. Specific Ocular Disease Considerations - 15 hours minimum

   a. Bacterial
   b. Viral and Chlamydial
   c. Allergic
   d. Fungal
   e. Clinical Diagnosis and Treatment of Anterior Uveitis
   f. Clinical Diagnosis and Management of Posterior Uveitis
   g. Lacrimal Disorders

II. Other Ocular Diseases/Disorders - 15 hours minimum

a. Pre-Post Operative Cataract Care
b. Integration of Nervous System Assessment and Neuro-Ophthalmic Disorders
c. Practical Management of Ocular Emergencies
d. Diabetic Complications - Diabetic Retinopathy
e. Sudden Vision Loss

III. Glaucoma Diagnosis, Treatment and Management - 10 hours minimum

a. Pathophysiology of Glaucoma
b. Open Angle Glaucoma
c. Angle Closure Glaucoma

IV. Clinical Laboratory Tests and Services - 3 hours minimum

At least 30 hours of Clinical Medical Perspectives/Primary Care Medicine for the Ophthalmic Practitioner that shall be taught by medical faculty members. The 30 hours shall be in the following areas:

a. Cardiovascular
b. Respiratory Disorders (e.g. Pulmonary)
c. Immunology
d. Infectious Disease
e. Dermatology
f. Cataract Surgery - 2 hours maximum
g. General Medical Emergency
h. Endocrinology
i. Collagen Vascular Disease

I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official	Signature of Chief Academic Officer
Title	Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____ , 20____.

Date of Expiration	Signature of Notary Public

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

IL486-1774 03/06 (OP)

INSTRUCTIONS FOR CONTROLLED SUBSTANCES REGISTRATION

****READ AND FOLLOW INSTRUCTIONS CAREFULLY****

If you hold a non-renewed controlled substances registration, you must reinstate that registration. Do not apply for a new registration.

Every person who prescribes and/or stores or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.

A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or dispensed.

1. If you do not properly complete Parts I through VII (front and back) of the application, the application will be returned to you and licensure will be delayed.
2. It is ***mandatory*** that the permanent mailing address and/or business address be a street address. **P.O. boxes are not acceptable. Your Controlled Substances registration must be issued to a street address.**
3. If your professional application is pending, write "pending" in Part IV. A controlled substances registration ***will not*** be issued until your professional license has been issued. A controlled substances registration ***will not*** be issued to individuals holding a temporary license.
4. You ***must*** circle each drug schedule for which you are applying in Part III.
5. You ***must*** complete and submit the CCA Form. Your application will not be processed without completion of this form.
6. Submit the $5 application fee. Make check or money order payable to the Department of Financial and Professional Regulation (IDFPR). **The fee is non-refundable**. Mail the completed application and fee to:

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

A State controlled substances registration is a **prerequisite** for Federal controlled substances registration. The address on your Illinois controlled substances registration must be exactly the same address as your Federal registration. For information concerning Federal registration, you must contact:

Drug Enforcement Administration
230 South Dearborn, Suite 1200
Chicago, Illinois 60604
Telephone: 312/353-7875
Web site: **www.deadiversion.usdoj.gov**

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.

FOR OFFICIAL USE ONLY

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☐336 Physician ☐377 APRN-FPA	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., M.D., O.D., etc.)

3. UNITED STATES SOCIAL SECURITY NO.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

4. PERMANENT MAILING ADDRESS CITY STATE/COUNTRY ZIP CODE COUNTY

___ ___ ___ ___ ___ + ___ ___ ___ ___

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED

6. EMAIL ADDRESS (REQUIRED)

7. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☐ I will ***not*** be storing or dispensing controlled substances, including samples.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work ( ) _____ **FAX** ( ) _____
Area Code Area Code

Home ( ) _____ **FAX** ( ) _____
Area Code Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II **III** **IV** **V**

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

	Professional License Number
☐ Dentist	019 - _____
☐ Optometrist	046 - _____
☐ Physician	036 - _____
☐ Podiatrist	016 - _____
☐ Veterinarian	090 - _____
☐ APN-FP	277 - _____

PART V: 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. *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.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		
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? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
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? If yes, attach a detailed explanation.		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.		
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

PART VI: Child Support 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.")

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

Date of Application _____ Signature of Applicant _____

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI):

SS#:

Profession: