Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

International Medical Graduate Temporary Practice Application

DIRECTIONS: Only physicians who are trained in a country other than the United States and are NOT LICENSED to practice medicine in any state or territory of the United States may use this form for approval to provide treatment under the supervision of an Illinois licensed physician and surgeon.

APPLICANT IDENTIFYING INFORMATION

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

SSN: _____ Date of Birth: _____ Country of Education:_____

License Number: _____ License State or Country: _____ License Expiry Date:_____

I attest that I meet the following qualifications:
My education has been be certified by ECFMG. Identification Number _____

I have passed Steps 1, 2 CK and 3 of the USMLE on the following dates:

Step 1 _____ Step 2 CK _____ Step 3 _____

PURSUANT TO 20ILCS 2105-165(a), THE DEPARTMENT REQUIRES THE DISCLOSURE OF INFORMATION REGARDING CONVICTIONS PERTAINING TO CERTAIN OFFENSES FOR THIS PROFESSION. YOU MUST RESPOND TO EACH OF THE FOLLOWING QUESTIONS:

1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? ☐ NO ☐ YES

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? ☐ NO ☐ YES

3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act
☐ NO ☐ YES

4) Are you currently charged with or have you been convicted of a forcible felony? ☐ NO ☐ YES

PERSONAL HISTORY FOR PHYSICIANS ONLY: COMPLETION OF THE QUESTIONS BELOW IS NECESSARY TO ACCOMPLISH THE REQUIREMENTS OUTLINED IN 225 ILCS 60 (MEDICAL PRACTICE ACT) OF THE ILLINOIS COMPILED STATUTES. DISCLOSURE OF THIS INFORMATION IS VOLUNTARY. HOWEVER, FAILURE TO COMPLY MAY RESULT IN THIS APPLICATION NOT BEING PROCESSED.

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. ☐ NO ☐ YES

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? If yes, attach a separate sheet with complete and accurate explanation. ☐ NO ☐ YES

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. 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. ☐ NO ☐ YES

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. ☐ NO ☐ YES

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. 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. ☐ NO ☐ YES

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? 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. ☐ NO ☐ YES

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. 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. ☐ NO ☐ YES

8) Do you have any disease or condition that interferes with 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, that presently interferes with your ability to practice your profession? If yes,attach a detailed statement, including an explanation whether or not you are currently under treatment. ☐ NO ☐ YES

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. I understand that I will be subject to all statutory and regulatory requirements of the MPA, 225 ILCS 60/1 relating to standard of care. I understand that I am limited to providing treatment under the supervision of a physician and surgeon actively licensed in Illinois to practice medicine in all branches pursuant to the Illinois Medical Practice Act.

Signature: _____ Date: _____

FOR EXPEDITED REVIEW AND SERVICE, EMAIL COMPLETED FORM TO: fpr.covidtemporaryapplication@illinois.gov.

You will receive a response via email.

All authorizations will have an expiration date of May 31, 2022 or until the expiration of the Gubernatorial COVID-19 Disaster Proclamation and a $0 fee.