INSTRUCTION / INFORMATION SHEET

ADVANCED PRACTICE REGISTERED NURSE - FULL PRACTICE AUTHORITY (Profession Code - 277)

- **Certified Nurse Midwife**
- **Certified Clinical Nurse Specialist**
- **Certified Nurse Practitioner**

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

Note: A CURRENT ILLINOIS REGISTERED NURSE LICENSE AND A CURRENT ILLINOIS ADVANCED PRACTICE REGISTERED NURSE LICENSE ARE REQUIRED FOR FULL PRACTICE AUTHORITY.

Before completing the application package, please read the following.

<u>APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE FULL PRACTICE AUTHORITY LICENSURE</u>

- ☐ **Part I, Box 5, page 1 -** Specify the category of advanced practice nursing for which your are applying. A separate fee **and application is required for each category.**
- ☐ **Part I, Box 6, page 1** - Indicate your current Illinois Registered Nurse License Number and Illinois APRN License Number.
- ☐ **Part II-V, pages 1 and 2** - Complete all applicable information requested in pages 1 and 2.

<u>APRN-FPA LICENSURE REQUIREMENTS</u>

- ☐ Specific instructions for each category of advanced practice registered nursing for which you are applying are located on the following pages.
- ☐ Locate the instructions for specific category you selected in **Part 1, Box 5 of the Application for Advanced Practice Nurse Licensure** and follow those instructions only.

<u>ASSISTANCE IN COMPLETING APPLICATIONS</u>

- ☐ If you need assistance in completing the application, you may call 1-800-560-6420 or (TTY) 1-866-325-4949. Inform the operator that you are applying for Advanced Practice Registered Nurse - Full Practice Authority Licensure and that you would like assistance in completing your application.

<u>APPLICATION FEE</u>

- ☐ The APRN-FPA application fee is **$125**. A separate fee and application are required for each category of licensure. The fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation. **THIS FEE IS NOT REFUNDABLE.**

<u>SUBMISSION OF APPLICATION</u>

- ☐ The two-page application, supporting documents and fee payment should be forwarded as a complete packet to:

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

<u>APPLICATION LICENSURE EXPIRATION</u>

- ☐ The application, which you submit, is valid for three (3) years from the date of receipt.
- ☐ All Illinois Advanced Practice Registered Nurse - Full Practice Authority licenses will expire on May 31 of every even-numbered year.

<u>NOTES:</u>

- Upon issuance of an APRN license with Full Practice Authority, the regular APRN license will go inactive.
- Prior to prescribing as an APRN granted Full Practice Authority, the APRN must apply for a practitioner license under the Illinois Controlled Substances Act.

The Illinois Nurse Practice Act and Rules and additional application forms for Advanced Practice Registered Nurse Licensure and for the Controlled Substance License can be downloaded from the IDFPR Web site at: <u>www.idfpr.illinois.gov</u>

CERTIFIED NURSE MIDWIFE

Submit the following documents and/or forms with the two-page application and fee:

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. A current copy of your national certification (certification or pocket card accepted) from one of the following:
   - The American College of Nurse Midwives (ACNM); **OR**
   - The American College of Nurse Midwives Certification Council (ACC)
3. Affidavit certifying 250 hours of additional Continuing Education (CE) or training.
4. Supporting Document **VE-APRN-FPA** must be completed indicating 4000 hours of clinical experience.

CERTIFIED NURSE PRACTITIONER

Submit the following documents and/or forms with the two-page application and fee:

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. A current copy of your national certification (certification or pocket card accepted) from one of the following:
   - American Academy of Nurse Practitioners Certification Program as a Nurse Practitioner
   - American Nurses Credentialing Center as a Nurse Practitioner
   - The Pediatric Nurse Certification Board as a Nurse Practitioner
   - The National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties as a Nurse Practitioner
   - The Certification Board for Urologic Nurses and Associates as a Urologic Nurse Practitioner.
3. Affidavit certifying 250 hours of additional Continuing Education (CE) or training.
4. Supporting Document **VE-APRN-FPA** must be completed indicating 4000 hours of clinical experience.

CERTIFIED CLINICAL NURSE SPECIALIST

Submit the following documents and/or forms with the two-page application and fee:

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

2. A current copy of your national certification (certification or pocket card accepted) from one of the following:

- American Nurses Credentialing Center (ANCC)
  - Clinical Nurse Specialist
  - Clinical Specialists in Community Health Nursing
  - Clinical Specialists in Gerontology Nursing
  - Clinical Specialists in Home Health Nursing
  - Clinical Specialists in Pediatric Nursing
  - Clinical Specialists in Psychiatric and Mental Health Nursing - Adults
  - Clinical Specialists in Psychiatric and Mental Health Nursing - Adolescent
  - Psychiatric and Mental Health Nursing
  - Cardiac and Vascular Nurse
  - College Health Nurse
  - Perinatal Nurse
  - Ambulatory Care Nursing
  - Diabetes
- American Association of Critical Care Nurses as a Clinical Nurse Specialist
- Rehabilitation Nursing Certification Board as a Certified Rehabilitation Registered Nurse--Advanced
- Oncology Nursing Certification Corporation as an Advanced Oncology Certified Nurse (AOCN)
- Certification Board for Urologic Nurses and Associates as a Urologic Clinical Nurse Specialist.
- American College of Cardiovascular Nursing
- American Association of Critical Care Nurses
- American Association of Neuroscience Nurses
- American Board of Occupational Health Nurses, Inc.
- American Holistic Nurses Association
- American Society of Perianesthesia Nurses
- American Society of Plastic Reconstructive Surgical Nurses
- Association of Nurses in AIDS Care
- Board of Certification of Emergency Nurses
- Certification Board of Perioperative Nurses, Inc.
- Certification of Pediatric Oncology Nurses
- Certification Board of Gastroenterology Nurses
- Dermatology Certification Board
- International Board of Lactation Consultants
- International Nurses Society of Addictions
- IV Nurses Certification Corporation
- National Association of School Nurses, Inc.
- National Board of Certification of Hospice and Palliative Nurses
- National Certification Board for Diabetes Educators
- National Certification Board of Pediatric Nurse Practitioners/Nurses
- National Certification Corporation for the Obstetric, Gynecological and Neonatal Nursing Specialties
- National Certifying Board for Ophthalmic Registered Nurses
- Nephrology Nursing Certification Board
- Oncology Nursing Certification Corporation
- Orthopedic Nurses Certification Board
- Rehabilitation Nursing Certification Board
- Vascular Nursing Certification Board
- Wound, Ostomy, and Continence Society

3. Affidavit certifying 250 hours of additional Continuing Education (CE) or training.

4. Supporting Document **VE-APRN-FPA** must be completed indicating 4000 hours of clinical experience.

SPECIAL INSTRUCTIONS FOR APPLICANTS SEEKING LICENSURE IN MORE THAN ONE ADVANCED PRACTICE NURSING CATEGORY

Applicants seeking licensure in more than one advanced practice nursing category may apply for licenses for multiple advanced practice nurse licensure categories if the applicant has met the requirements for at least one advanced practice nursing specialty; and

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

2. Submits proof in the form of official transcripts with the school seal affixed that he/she possesses an additional graduate education that results in a certificate for another clinical advanced practice nurse category and that meets the requirements for the national certification from the appropriate nursing specialty; and

3. He/she submits a copy of a current, national certification from the appropriate certifying body for that additional advanced practice nursing category.

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."**

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Advanced Practice Registered Nurse - Full Practice Authority

In order for your application to be processed,
<u>ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED</u>
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!

TWO-PAGE APPLICATION REVIEW		**COMPLETED**
Part I.	Application Category Information	
Part II.	Applicant Identifying Information	
Part III.	Personal History Information	
Part IV.	Child Support and/or Taxes	
Part V.	Certifying Statement--Signed and Dated	

SUPPORTING DOCUMENTS	**SUBMITTED**
2-page Application for Licensure and/or Examination	
Application Fee--$125;	
Supporting Document CCA **<u>must</u>** be completed and submitted with each application. Your application will not be processed without completion of this form.	
CURRENT COPY OF NATIONAL CERTIFICATION	
VE APRN-FPA form **<u>must</u>** indicate 4000 hours of clinical experience	
AFFIDAVIT certifying the completion of 250 additional Continuing Education or Training	

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

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ilcs 65/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE - FULL PRACTICE AUTHORITY LICENSURE

A CURRENT ILLINOIS REGISTERED NURSE LICENSE IS REQUIRED FOR ADVANCED PRACTICE REGISTERED NURSE - FULL PRACTICE AUTHORITY LICENSURE

The following materials are required to make application for an Advanced Practice Nursing license in Illinois:

1. APPLICATION FOR ADVANCED PRACTICE NURSE LICENSURE.
2. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
3. 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.

A. Type or print legibly with black ink only.

B. The fee is $125 - Make check payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each category of APN licensure.)

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. 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	3. LICENSURE METHOD	4. FEE
Advanced Practice Registered Nurse - Full Practice Authority	**277**	**Non-examination**	**$125**

5. CHECK ONE OF THE FOLLOWING BOXES INDICATING THE CATEGORY OF ADVANCED PRACTICE NURSE:

☐ Certified Clinical Nurse Specialist ☐ Certified Nurse Practitioner
☐ Certified Nurse Midwife

6. INDICATE YOUR CURRENT ILLINOIS REGISTERED NURSE AND APRN LICENSE NUMBERS:
041-
209 -

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., APN Specialty)

3. UNITED STATES SOCIAL SECURITY NO. ___ ___ ___ – ___ ___ – ___ ___ ___ ___

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

5. MAIDEN, GIVEN, OR OTHER USED NAME(S)

6. PLACE OF BIRTH (CITY, STATE/COUNTRY)

7. DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

8. ☐ Female ☐ Male

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ (Area Code)

Home: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ (Area Code)

Fax: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ (Area Code)

E-MAIL ADDRESS (REQUIRED) _____

PART III: 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.*		

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

PART III: Personal History Information *(This part must be completed by all applicants) (CONTINUED)*

	YES	NO
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 IV: 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 V: 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.

AFFIDAVIT OF CE / TRAINING

SUPPORTING DOCUMENT

AF-APRN-FPA

APPLICANT: ***Complete the applicant section of this form.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ – __ __ – __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE		
6. MAIDEN OR GIVEN SURNAME		

I hereby certify to the following:

* I have completed at least 250 hours of continuing education or training in compliance with Section 1300.465.
* The CE or training in question is the area of certification used to obtain my APRN license.
* I will provide proof of completion to the Department upon request.

Signature of Applicant _____ Date _____

Signature of Notary _____ 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.

VERIFICATION OF EXPERIENCE

SUPPORTING DOCUMENT

VE-APRN-FPA

APPLICANT: ***Complete the applicant section of this form.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ – __ __ – __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE		
6. MAIDEN OR GIVEN SURNAME		

INSTRUCTIONS: Multiple copies of this form may be submitted to document completion of the required 4000 hours of clinical experience. The top portion must be completed by the collaborating physician(s) or hospital designee. The bottom portion must be completed by the Applicant and must be notarized.

I _____ hereby certify that the applicant has completed _____ hours
Name of Physician or Hospital Medical Staff Committee/Designee

of clinical experience after first attaining national certification in accordance with Section 1300.465 of the Illinois Rules for the Administration of the Nurse Practice Act.

_____ _____
Signature of Physician or Hospital Medical Staff Committee/Designee — Date

NOTE: Only the signature of the applicant must be notarized.

I_____ hereby certify that I have completed _____ hours of clinical experience with the above physician or hospital. I agree to provide proof of completion of the hours to the Department upon request.

_____ _____
Signature of Applicant — Date

_____ _____
Signature of Notary — 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

2. ADDRESS STREET, CITY, STATE, ZIP CODE

3. PROFESSIONAL LICENSE NUMBER (if any)
___ - _____

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.

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.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

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 ☐316 Podiatrist ☐336 Physician	☐346 Optometrist ☐390 Veterinarian ☐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 - _____

NAME (Last, First, MI):

SS#:

Profession:

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.