IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 25/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF ACCEPTANCE FOR SPECIALTY/RESIDENCY TRAINING

SUPPORTING DOCUMENT

CA-DEN

NOTE: An applicant who has filed an Application for Licensure and/or Examination with the Department and has met all requirements for licensure will be permitted to practice dentistry for a period of 3 months from the starting date of the program, unless authorized in writing by the Department to continue such practice for a period specified in writing by the Department. The authority to practice shall terminate immediately upon: (1) the decision of the Department that the applicant has failed the examination; or (2) denial of licensure by the Department; or (3) withdrawal of the application.

APPLICANT: Complete the applicant section of this form, then forward it to the dental school/public health agency/ hospital that has accepted you for specialty/residency training, for completion of the remainder of the form.					
1. NAME	LAST	FIRST	MIDDLE	2. DATE OF BIRTH / / Month Day Year	3. SSN OR ITIN
4. ADDRESS STREET, CITY, STATE, ZIP CODE				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 SURN	IAME
ADMINISTRATOR: Complete the remainder of this form, then return the form to the applicant.					
A. DENTAL SC	AL SCHOOL/HOSPITAL/INSTITUTION NAME B. BEGINNING DATE				
				Month Day Year	
C. BUSINESS A	ADDRESS STRE	ET, CITY, STATE, ZIP	CODE	D. ENDING DATE	
				Month Day Year	
E. BUSINESS	TELEPHONE NU	IMBER		F. SPECIALTY/RESIDENCY NAME	G. YEAR OF POSTGRADUATE TRAINING
Area Code (()	_			
I do hereby declare that the above-named applicant has been accepted or appointed for specialty/residency training as indicated above. Upon notification that the applicant has failed the examination; or licensure is denied by the Department; or the application is withdrawn, I understand the authority to practice shall terminate immediately.					
			_		
				Signature of Dean/Hospital Administrator	
SEAL _			-	Print Name of Dean/Hospital Administrator	
_			_	Title	
_			_	Date	