INSTRUCTION SHEET

PHYSICIAN AND SURGEON

Temporary Licensure
Limited Temporary Licensure
● **Transfer of Temporary Licensure**
Extension of Temporary Licensure

Table of Contents

	Page
Fees	2
Educational Requirements	2
Professional Capacity Qualifications	3
Applying for Licensure	4
General Instructions	4
Filing Instructions for Temporary Licensure	4
Temporary Licensure for Individuals Who Graduated from Approved U.S. or Canadian Colleges	4
Temporary Licensure for Individuals who graduated from NON-LCME Approved Colleges	5
Transfer of Temporary License	6
Extension/Reissue of Temporary License	6
Limited Temporary License	7
Forms Completion Guide	8

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

FEES

PROFESSION NAME	PROFESSION CODE	LICENSURE METHOD	APPLICATION FEE
Temporary Physician Licensure	125	Nonexamination	$230.00
Temporary Physician Transfer	125	Nonexamination	$ 20.00
Temporary Physician Extension/Reissue	125	Nonexamination	$100.00
Limited Temporary Physician Licensure	130	Nonexamination	$100.00
Limited Temporary Physician Transfer/Reissue	130	Nonexamination	$ 20.00

EDUCATIONAL REQUIREMENTS

In order to be considered for licensure in Illinois, an applicant must have completed a 6 year postsecondary course of study comprising of:

Preprofessional Education

2-year course of instruction, in a liberal arts or medical college.

Professional Education

Graduation from a medical or osteopathic college officially recognized by the jurisdiction in which it is located for the purpose of receiving a license to practice medicine in all of its branches comprised of:

1. at least 2 academic years of study in the basic medical sciences; and

2. 2 academic years of study in the clinical sciences while enrolled in the medical college which conferred the degree and with the stipulation that the core rotations of which must have been either:

   a) in clinical teaching facilities owned, operated, or formally affiliated with the medical college which conferred the degree; or

   b) under contract in teaching facilities owned, operated, or affiliated with another medical college which is officially recognized by the jurisdiction in which the medical school which conferred the degree is located; or

   c) graduated from a medical or osteopathic college accredited by the Liaison Committee on Medical Education or the American Osteopathic Bureau of Professional Education.

PROFESSIONAL CAPACITY

Any applicant applying for temporary licensure who has not been engaged in the active practice of medicine or has not been enrolled in a medical program for 5 years prior to application must submit proof of professional capacity to the Department.

In determining professional capacity, the Department may consider the following criteria as they relate to an applicant:

(1) Medical research in an established research facility, hospital, college or university, or private corporation.

(2) Specialized training or education.

(3) Publication of original work in learned, medical, or scientific journals.

(4) Participation in federal, State, local, or international public health programs or organizations.

(5) Professional service in a federal veterans or military institution.

(6) Any other professional activities deemed to maintain and enhance the clinical capabilities of the applicant.

You must forward to the Department a detailed statement that clearly identifies each activity specified above that you have completed in the 2 years prior to your application that you wish the Department to consider in determining your professional capacity. The statement must be signed and dated. You must also provide documentation verifying that you have completed each activity in the 2 years prior to your application.

Upon review, the Department may require completion of additional testing, training, or remedial education deemed necessary in order to establish the applicant's present capacity to practice medicine with reasonable judgment, skill, and safety.

APPLYING FOR LICENSURE

GENERAL INSTRUCTIONS

1. Read these instructions; then read "Filing Instructions for Temporary Licensure," to determine the basis under which you must comply and the documentation and forms you must submit.

2. **All documents in a foreign language** must be accompanied by an original, notarized translation that has been transcribed 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.

Forward the four-page application, supporting documentation, and fee to:

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

3. Read the applicable section of the "Forms Completion Guide" (pages 8 through 10) for information concerning 4-page application and Supporting Documents prior to completing the applicable forms. You may photocopy any of the enclosed forms if additional forms are needed.

4. To determine the fee, consult the Fee Section, page 2. Fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation.

5. After receipt and review of the completed application by the Department, if determination of eligibility cannot be made, you will be notified to appear for an interview before the Medical Licensing Board at a regularly scheduled board meeting.

6. The temporary license is issued to the hospital where clinical training is to be completed. All inquiries and correspondence from the Department **will** be directed to the Graduate Medical Education (GME) office of the hospital.

7. All applications for temporary licensure, including limited licenses, reissued licenses, transfers, and extensions must be on file a minimum of **60 days prior to the commencement date of the training**.

8. The GME office of the hospital may contact the Department directly to obtain the updated status of your application. Deficiency notices and all other correspondence regarding your application will be directed to the GME office. If you need any further assistance, please contact the GME office at the hospital.

FILING INSTRUCTIONS FOR TEMPORARY LICENSURE

Temporary Licensure for Individuals who Graduated from Approved U.S. or Canadian Colleges

Graduates of approved U. S. or Canadian colleges, must submit the following in order to be considered for temporary licensure (read the above *General Instructions* before proceeding):

a. Application for Licensure;

b. **PHQ** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. **VE-PC** Verification of Employment/Experience--Professional Capacity;

e. **CT** Certification of Licensure, if applicable;

f. **CA-MED** Certification of Acceptance for Specialty/Residency Training (this form must be signed by the residency program director);

FILING INSTRUCTIONS FOR LICENSURE *(cont'd)*

g. Fee;

h. An official transcript verifying a minimum of 2 years liberal arts/pre-medical education with school seal affixed;

i. An official medical transcipt listing the type and exact date the degree was conferred with the school seal affixed if applicant has graduated.

- For applicants who have not officially graduated, submit an official transcript verifying medical education completed to date, with school seal affixed, **ALONG** with the ED-MED (Certification of Graduation) completed by the dean or registrar of the medical school. ED-MED and transcript may **not** be certified more than 45 days prior to the graduation date.

j. Individuals who graduated from a medical or osteopathic college more than 5 years prior to date of application for licensure, not actively engaged in the practice of medicine or engaged in a formal program of medical education in another state, territory, country, or province in addition to meeting all requirements for licensure, must submit documentation to the department evidencing professional capacity since graduation from medical school. Refer to page 3 for specific information regarding acceptable documentation to evidence continuing clinical skills.

Temporary Licensure for Individuals who Graduated from NON-LCME Approved Colleges

Individuals who did not graduate from medical or osteopathic college accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools in conjunction with the Liaison Committee on Medical Education, or the American Osteopathic Bureau on Professional Education must submit the following in order to be considered for temporary licensure (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure;

b. **PHQ form must be completed by all applicants**;

c. **PH** form must be completed by all applicants;

d. **VE-PC** Verification of Employment/Experience--Professional Capacity;

e. **CT** Certification of Licensure, if applicable;

f. An official transcript with school seal affixed verifying a minimum of 2 years liberal arts/pre-medical education (see *Educational Requirements*, page 2);

g. An official medical school transcript with school seal affixed (see *Educational Requirements*, page 2);

h. A copy of your original medical school diploma if graduation date and degree conferred is not on transcript;

i. **CA-MED** Certification of Acceptance for Specialty/Residency Training (this form must be signed by the residency program director);

j. Verification of valid E.C.F.M.G.. certification;

k. Fee;

l. Individuals graduating from a Fifth Pathway program must submit, in addition to all of the documents requested above, verification of completion of an approved Fifth Pathway program.

m. Individuals must submit proof of completion of internship or social service if required prior to the granting of their degree in lieu of ECFMG certification.

International Medical Graduates

Documents received in the mail will not be returned.

If a document cannot be replaced, do not mail the original document. Instead, mail a notarized copy of the original document to the IDFPR.

FILING INSTRUCTIONS FOR LICENSURE *(cont'd)*

n. Individuals who graduated from a medical or osteopathic college more than 5 years prior to the date of application for licensure, not actively engaged in the practice of medicine or engaged in a formal program of medical education in another state, territory, country, or province, in addition to meeting all requirements for licensure, must submit documentation to the Department evidencing professional capacity since graduation from medical school. Refer to page 3 for specific information regarding acceptable documentation to evidence continuing clinical skills.

Transfer of Temporary License

A transfer of temporary license is only applicable if you received an initial temporary license for less than 3 years or if you changed specialties within the first 3 years of your training. In order to transfer your temporary license you must submit the following (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure

b. **PHQ** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. A letter from the program director explaining why a transfer is required.

e. **CA-MED** Certification of Acceptance for Speciality/Residency (This form must be signed by the residency program director.)

f. Fee.

Extension/Reissue of Temporary License

Temporary licenses may be extended only in the following documented situations: 1) serving full-time in the Armed Forces; 2) an incapacitating illness; 3) continuance of a residency training program in order to meet the remedial requirements to retake the licensure examination, 4) continuance of a residency training program within ACGME or AOA guidelines. **The Department allows for a 14-day extension beyond the expiration of the temporary license without filing an application to extend.** In order to request an extension submit the following (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure

b. **PHQ** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. A letter from the program director explaining why an extension reissue is required;

e. **CA-MED** Certification of Acceptance for Specialty/Residency (this form must be signed by the residency program director);

f. Fee.

Limited Temporary License

To be eligible for a 6-month limited temporary license, an applicant must be enrolled in an approved training program in another state and be accepted in an approved clinical training program in Illinois due to the absence of adequate facilities in the other state. In order to request a limited temporary license, submit the following (read *General Instructions*, page 4, before proceeding):

FILING INSTRUCTIONS FOR LICENSURE *(cont'd)*

facilities in the other state. In order to request a limited temporary license, submit the following (read *General Instructions*, page 4, before proceeding):

a. Application for Licensure;

b. **PHQ** form must be completed by all applicants;

c. **PH** form must be completed by all applicants;

d. **CT** Certification of Licensure, if applicable;

e. **TEMP-LTD** Certification of Acceptance for a Limited Specialty/Residency Program in Illinois (this form must be signed by the Illinois and out-of-state residency program director); and

f. Fee.

FORMS COMPLETION GUIDE

This guide will help you complete the forms needed to apply for licensure. For information regarding the forms which you will be required to submit, refer to the section entitled *Filing Instructions for Temporary Licensure*.

Application for Licensure and/or Examination

Provide all applicable information requested on all four pages of the application. The following will assist you in this endeavor.

1. Part 1-A--Use the Reference Sheet (Chart 1) to record the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee.

   Part 1-B--Check the box indicating the appropriate information regarding your application.

2. Part II--Enter all applicable information requested.

3. Part III--Education Information.

   a. Numbers 1 through 5--Enter all applicable information requested.
   b. Number 6--Indicate every college, university or medical school attended, along with dates of attendance.
   c. Number 7--Indicate all postgraduate clinical training including specialty/residency/intern/training.

4. Part IV--Record of Licensure Information--Individuals licensed in a U.S. jurisdiction or a foreign country or province must state whether or not they have ever held licensure (either permanent or temporary) to practice as a physician/surgeon.

5. Part V--Record of Examination--List all examinations taken to qualify for physician licensure; i.e., FLEX, National Boards, and USMLE. Each examination attempt and date taken must be shown.

6. Part VI--Personal History Information--You must answer all 6 questions either "yes" or "no." If any of your responses to numbers 1 through 6 are "yes," submit a detailed statement explaining your affirmative response(s) and any and all applicable information as indicated below. Upon completion of your application, further review will be required.

   Question 1-2 A certified copy of all court records (other than minor traffic violations) regarding your conviction of a criminal or driving offense in any county, state, circuit or federal court, including a copy of the police report(s); if probation given, verification that probation was completed satisfactorily; a copy of all proceedings regarding the conviction and final disposition of the charge(s) direct from the court(s).

   Submit a statement for each conviction indicating date and place of conviction, nature of the offense, and if applicable, the date of discharge from any penalty imposed.

   Question 3 If you have been issued a Certificate of Relief from Disabilities by the Prisoner Review Board, you must include a copy of the certificate.

therapists from whom you are currently receiving treatment for any chronic disease or condition (i.e., chemical/alcohol dependency, depression, etc.). The report must include dates of treatment, method of treatment, diagnosis, and prognosis. Attach a detailed statement advising whether you are currently under treatment.

Submit a copy of each of your treating physician's curriculum vitae and verification of board certification if board certified in a specialty.

If you are currently receiving treatment as an inpatient/ outpatient at any time for any disease or condition, then it will be necessary for you to have the institution(s) submit, directly to this Department, copies of any and all admitting histories, physicals and discharge summaries for each inpatient/outpatient stay or treatment.

Question 5 A detailed explanation is required if you have 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. Information from every state licensing board or licensing entity must be submitted regarding discipline, probation, suspension, censure, restriction, limitation, or revocation of your license, permit, work letter, or certificate to practice medicine or denial of your privilege of taking an examination. The information from each and every state must include the statement of charges, ALL proceedings regarding charges, and disposition of the charges.

Question 6 If you have ever been discharged other than honorably from any branch of the armed service, or from any city, county, state, or federal position, request the appropriate entity to forward, directly to this Department, any and all information relative to your discharge.

7. Part VII--Do not complete this part.
8. Part VIII--This part must be completed by all applicants.
9. Part IX--Read the certifying statement and then sign and date your application.

PHQ Form This form is to be completed by all applicants pursuant to ILCS 2105-165(a).

PH Form This form must be completed by all applicants.

FORMS COMPLETION GUIDE *(cont'd)*

VE-PC **Verification of Employment/ Experience--Professional Capacity**	This form is to be completed by all applicants. Record your work history chronologically for the five (5) years preceding the date of application beginning with present employment.
CT **Certification of Licensure**	This document must be completed by the jurisdiction of original licensure and the jurisdiction where you have most recently been practicing. This applies to individuals licensed in a U.S. jurisdiction or foreign country or province. NOTE: You must direct the licensing entity to return the completed form **directly** to you.
CA-MED **Certification of Acceptance for Specialty/Residency Training**	This form is to be completed by the program director of the specialty/ residency program to which you applied.
ED-MED **Certification of Graduation**	Current year graduates of approved U.S. or Canadian medical schools, who have not been awarded a medical degree, must submit the ED-MED form, along with an official current transcript, completed by the dean or registrar of the medical school they attended. The ED-MED form and transcript cannot be certified more than 30 days prior to the graduation date.
TEMP-LTD **Certificate of Acceptance and Enrollment for a Limited Specialty/Residency Program**	This form msut be completed and signed by the program director of the Illinois specialty/residency training program for which the applicant is applying and the residency program director for the out-of-state program.

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."**

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Temporary Physician

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!

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 Form	
PH Form	
CT (Certificate of Licensure) Form from original and current jurisdictions of licensure	
VE-PC Form	
CA-MED Form	
ECFMG Certificate (copy), if applicable	
Proof of Pre-Medical and Medical Education	
Medical School Diploma (copy), if applicable	
ED-NON Form, if applicable	
5th Pathway/Social Service, if applicable	
TEMP-LTD Form (Limited Temporary License Only)	

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

This page intentionally left blank for double-sided printing.

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. SSN OR ITIN
		__ __ __ – __ __ – __ __ __ __

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

Work: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

Home: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

Fax: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

Fax: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

12. **REQUIRED** E-MAIL ADDRESS

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

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

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 Received OR 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 FROM	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
		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 FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
		Month/Year	Month/Year	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SSN OR ITIN:

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):

SSN OR ITIN:

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, Tax Information and Workers' Compensation (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 ☐

3. In accordance with 20 ILCS 2105/2105-15(g-5), "The Department shall refuse the issuance or renewal of a license to, or suspend or revoke the license of, any individual, corporation, partnership, or other business entity that has been found by the Illinois Workers' Compensation Commission or the Department of Insurance to have failed to secure workers' compensation obligations, or pay in full a fine or penalty imposed due to a failure to secure workers' compensation obligations."

   Are you delinquent in complying with workers' compensation obligations? 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. **I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.**

Signature of Applicant

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.

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

PH

NAME LAST	FIRST	MIDDLE	SSN OR ITIN
			__ __ __ – __ __ – __ __ __ __

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
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.		
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.*		
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.*		
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.		
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.*		
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.*		
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 a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		

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

Date

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 20 ILCS 2105 of the Civil Administrative Code. Disclosure of this information is REQUIRED.

HEALTH CARE WORKERS ADDITIONAL PERSONAL HISTORY QUESTIONS

SUPPORTING DOCUMENT

PHQ

1. NAME LAST FIRST MIDDLE

2. ADDRESS STREET, CITY, STATE, ZIP CODE

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

4. SOCIAL SECURITY NUMBER OR ITIN
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Pursuant to 20 ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding charges or convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturist
- ☐ Advanced Practice Registered Nurse
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainer
- ☐ Audiologist
- ☐ Behavior Analyst
- ☐ Behavior Analyst Assistant
- ☐ Certified Midwife
- ☐ Chiropractic Physicians (D.C.)
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Genetic Counselor
- ☐ Licensed Practical Nurse
- ☐ Marriage and Family Therapist
- ☐ Marriage and Family Therapist Assoc.
- ☐ Music Therapist
- ☐ Naprapath
- ☐ Nursing Home Administrator
- ☐ Occupational Therapist
- ☐ Occupational Therapy Assistant
- ☐ Optometrist
- ☐ Orthotist
- ☐ Pedorthist
- ☐ Perfusionist
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physical Therapy Assistant
- ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.)
- ☐ Physician Assistant
- ☐ Professional Counselor (LPC)
- ☐ Professional Counselor, Clinical (LCPC)
- ☐ Psychologist, Clinical (LCP)
- ☐ Podiatrist
- ☐ Prosthetist
- ☐ Registered Nurse
- ☐ Registered Surgical Assistant
- ☐ Registered Surgical Technologist
- ☐ Respiratory Care Practitioner
- ☐ Sex Offender Associate
- ☐ Sex Offender Evaluator
- ☐ Sex Offender Treatment Provider
- ☐ Social Worker (LSW)
- ☐ Social Worker, Clinical (LCSW)
- ☐ Speech Pathologist

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 personal statement describing the circumstances of the charge or conviction and a certified copy of the court records regarding your charge or conviction, including 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.

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-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

__ __ / __ __ / __ __ __ __
Month Day Year

5. SSN OR ITIN

__ __ __ - __ __ - __ __ __ __

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☐ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. TODAY'S DATE

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

C. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

F. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATE OF ACCEPTANCE FOR POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence postgraduate clinical training before the sponsoring institution verifies with the Department of Financial and Professional Regulation that the applicant's licensure has been approved.

APPLICANT: Complete the applicant section of this form, then forward it to the institution sponsoring your internship, residency, or clinical fellowship to complete 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*		
5. *MAIDEN OR GIVEN SURNAME*		

ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.

A. *NAME OF SPONSORING INSTITUTION*	B. *START DATE* __ __ / __ __ / __ __ __ __ Month Day Year	C. *END DATE* __ __ / __ __ / __ __ __ __ Month Day Year
D. *PROGRAM SITE (STREET ADDRESS, CITY, STATE, ZIP CODE)*	E. *SPECIALTY NAME AND PROGRAM LENGTH*	
F. PROGRAM EMAIL AND TELEPHONE NUMBER Email: _____ Area Code (__ __ __) __ __ __— __ __ __ __	G. *POST-GRADUATE YEAR (PGY) FOR DATES LISTED ABOVE, e.g., PGY1-3, PGY4.*	

I do hereby declare that the above named applicant will be accepted for postgraduate clinical training as detailed above if, subsequent to evaluation by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

_____
Signature of Program Director

_____
Print Name of Program Director

SEAL

_____
Title

_____
Date