

# INSTRUCTION SHEET

## Licensed Professional Counselor or Licensed Clinical Professional Counselor Examination Acceptance of Examination Endorsement Restoration

The requirements of licensure and practice for Illinois Licensed Professional Counselor (LPC) licensure or Illinois Licensed Clinical Professional Counselor (LCPC) licensure are provided by the ACT (225 ILCS 107/) and the RULES in Administrative Code (68 IAC Part 1375).

The ACT and RULES are available online at: <https://idfpr.illinois.gov/profs/ProfCounselor.html>

### STEP 1.

Determine the level of license desired. There are two tiers of Professional Counselor licensure:

**Licensed Professional Counselor (LPC)** – Licensed Professional Counselors may NOT practice independently and must operate at all times under the order, control, and professional responsibility of a Licensed Clinical Professional Counselor (LCPC), a Licensed Clinical Social Worker (LCSW), A Licensed Clinical Psychologist, or a psychiatrist as defined in Section 1-121 of the Mental Health and Developmental Disabilities Code.

**Required examination:** Either the National Board for Certified Counselors (NBCC)'s National Counselor Examination (NCE) **OR** the Commission on Rehabilitation Counselor Certification (CRCC) Certified Rehabilitation Counselor Examination (CRCE). An applicant for Illinois LPC licensure who has not yet completed one of these exams will be required to complete one as part of the Illinois LPC licensing process.

**The National Clinical Mental Health Counselor Examination (NCMHCE) is NOT acceptable for Illinois LPC licensure.**

**Licensed Clinical Professional Counselor (LCPC)** – This is the independent practice level license.

**Required examinations:** Either the Commission on Rehabilitation Counselor Certification (CRCC) Certified Rehabilitation Counselor Examination (CRCE), **OR BOTH** the National Board for Certified Counselors (NBCC)'s National Counselor Examination (NCE) **AND** National Clinical Mental Health Counselor Examination (NCMHCE).

**An applicant for Illinois LCPC licensure who has completed only NCE or only NCMHCE will be required to successfully complete whichever examination they have not yet completed (NCE or NCMHCE) as part of the Illinois licensing process.**

**For more information about the required licensure examination(s), please refer to:**

LPC – Rules 68 IAC Section 1375.60

LCPC- Rules 68 IAC Section 1375.150

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## STEP 2.

There are four (4) pathways (or LICENSURE METHODS) to Illinois LPC or LCPC licensure. Use the descriptions below to determine the appropriate LICENSURE METHOD.

**ENDORSEMENT-** This licensure method is for someone who is **ACTIVELY** licensed as an LPC or LCPC (or equivalent license) in *another* state or US jurisdiction. Someone who has another state license that is **NOT ACTIVE** is not eligible for this licensure method. The license must be **ACTIVE**. **An individual who has not completed the required exam(s) will be required to complete them as part of the Illinois licensing process.** For more information about the required licensing examination(s) please see STEP 1 of these instructions.

**ACCEPTANCE OF EXAMINATION-** This licensure method is for someone who is **NOT ACTIVELY** licensed, and who does not need IDFPF approval to sit for the licensing examination. A person who applies under this licensure method is asking IDFPF to “accept” or “recognize” an examination completed on a different pathway or without IDFPF approval.

This is the licensure method for someone who has already completed or intends to complete the NCE or NCMHCE through one of NBCC’s Certification pathways or through their university’s counseling program.

This is the licensure method for someone who has completed or plans to complete the CRCE.

This is the licensure method for an Illinois Licensed Clinical Social Worker (LCSW) or Licensed Clinical Psychologist applying for LCPC licensure under the language of Rules 68 IAC Section 1375.135.

**EXAMINATION (PRE-EXAM APPROVAL)-** This licensure method is for someone who **wants or needs IDFPF approval to sit for the required licensing exam**, either the NCE or NCMHCE.

**For more information about the required licensing examination(s) please see STEP 1 of these instructions.**

**RESTORATION-** This licensure method is for someone who is attempting to reactivate an Illinois LPC or LCPC license that has been inactive or not renewed for five (5) years or more. Candidates seeking to reactivate a license that is not renewed or inactive may contact the DPR call center at 1-800-560-6420 to request instructions, forms and fees.

## STEP 3.

Use the Licensure Method from STEP 2 and the chart below to complete **PART I** (Page 1), Box A., Items 1-4 of the application.

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Licensed Professional Counselor (LPC)	178	From STEP 2.	\$150
Licensed Clinical Professional Counselor (LCPC)	180		(all methods except Restoration- Restoration fee \$300).

## STEP 4.

Complete the rest of the 4-page application, noting the following:

**PART III: BOX 7. Specialized Training** (Page 2, Bottom). Please list all internship & practicum experiences. LCPC applicants please list all supervised post-degree experiences which you intend to count towards the supervised professional experience requirements of Rules 68 IAC Section 1375.130.

**PART IV: Record of Licensure Information** (Page 3). Applicants who have never held a counseling license may mark N/A for “not available” or “not applicable”.

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**PART V:** Record of Examination (Page 3). All attempts (pass or fail) of the following exams (among others) must be listed: The National Counselor Examination (NCE), The National Clinical Mental Health Counselor Examination (NCMHCE), The Certified Rehabilitation Counselor Exam (CRCE). Candidates who have never taken a licensure examination may mark N/A for “not available” or “not applicable”.

**PART VII:** Examination Coding Information (Page 4). This portion of the application is not used for LPC or LCPC applications. Please leave this part of the application blank or mark N/A for "not applicable". A separate examination registration process is followed when an applicant has been approved to take the exam.

## STEP 5.

**SUPPORTING DOCUMENTS** - The following supporting documents may be required with your application. Read the instructions for each form thoughtfully.

**\$150 Licensure Application fee** - Please make your check or money order payable to IDFPR. DO NOT SEND CASH. (All methods except RESTORATION. RESTORATION fee is \$300.)

**PHQ form** - This form is required to be completed by all applicants.

**ED-PC form(s)** - This form is NOT required for RESTORATION applications. This form is NOT required for graduates of counseling programs located outside the United States. This form required for MOST other applications. The applicant completes the “APPLICANT” portion of the form, then arranges for his or her graduate level counseling program college or university to complete the “SCHOOL OFFICIAL” portion of the form. The school official’s original signature and seal is required, do not submit photocopies. Do not submit the form unless it has been completed by the counseling program. Do NOT submit forms for undergraduate coursework. A separate form is required for each college or university through which graduate level counseling coursework was completed. Education requirements are detailed in RULES Section 1375.45 (LPC) and RULES Section 1375.145 (LCPC).

**International Credentials Evaluation** – Graduates of programs located outside the United States must provide a Course-by-Course Foreign Credentials Evaluation from a reputable, recognized international credential evaluation service, such as ECE or WES.

**CT form** - A candidate who is licensed as a counselor in another state or U.S. Jurisdiction must provide Certification of Licensure from his or her first state of counseling licensure and the state she or he has most recently been practicing. The applicant must contact the appropriate Board or Agency in the other state(s) to arrange for an original Certification of Licensure to be sent directly to the Department. IDFPR will accept other state’s formats of Certification in lieu of the CT form if the other state format includes the required minimum information.

**Official Score Report** - A candidate applying under the ACCEPTANCE OF EXAMINATION or ENDORSEMENT licensure methods must arrange for an official, original licensure exam score report to be sent directly to the Department. Candidates who have completed either the National Counselor Examination (NCE), the National Clinical Mental Health Counselor Examination (NCMHCE), or the Certified Rehabilitation Counselor Examination (CRCE) must submit an official score report. **An LCPC (180) applicant who completed the NCE exam through their University or through one of NBCC’s Certification pathways must arrange for an official NCE score report to be provided directly to IDFPR from NBCC/CCE, even if they are already hold Illinois LPC (178) licensure.**

**NCC or CRC Certificate** - This document is optional. A National Certified Counselor (NCC) or Certified Rehabilitation Counselor (CRC) may submit a photocopy of his or her certification certificate instead of the ED-PC form.

**Personal History Documents** - An applicant marking “YES” in response to any of the personal history questions in PART VI, page 4 of the application will need to provide a signed personal statement of explanation and corresponding documentation. For criminal issues please provide a certified copy of the disposition from the court or a statement from the court why one is not available. For medical disclosures please provide a physician’s statement that includes whether or not the condition being disclosed will prevent you from performing the essential functions of a professional counselor.

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**Proof of name change(s)** - If any of the supporting documents listed above list a different name than the name on the application, proof of name change(s) must be submitted. An applicant must document each step of each change. Examples of acceptable documentation include: Signed Marriage Certificates, Marriage Licenses, Divorce Decrees, Court orders showing change(s) of name.

**VE-LCPC (LCPC only)** - This form is required for LCPC applications only. The applicant completes the “APPLICANT” portion of the form, then arranges for the supervisor to complete the “SUPERVISOR” portion of the form. The Supervisor’s original signature is required- photocopies are not acceptable. An individual applying under the ENDORSEMENT licensure method who has been licensed at the independent level in another state or U.S. jurisdiction for 5 consecutive years without discipline may submit Certification of Licensure (CT forms) for each state in which the applicant practiced in the last 5 years instead of documenting supervised experiences with form VE-LCPC. Supervised experience requirements are detailed in RULES Section 1375.130.

**RS form (Restoration Licensure Method only)** - The RS form is not available online and must be obtained by contacting the Department. Candidates seeking to reactivate a license that is not-renewed or inactive may contact the DPR call center 800/560-6420 to request instructions, forms and fees.

**Continuing Education (Restoration Licensure Method only)** - Candidates seeking to reactivate a license may submit documentation of Continuing Education (CE) such as certificates of attendance. All CE must be completed in accordance with Counselor Administrative Rules (68 IAC Section 1375.220 and 68 IAC Section 1130.Subpart E). Candidates applying on the basis of the RESTORATION licensure method are NOT required to submit the ED-PC form.

The application, supporting documents, and application fee may be submitted with the application or separately to:

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

An application is valid for 3 years from date it is received by the Department.

Additional application forms can be downloaded from the IDFPR Web site at <https://idfpr.illinois.gov>.

For assistance -- Call one of the following numbers and state that you are applying to become licensed as a professional counselor and need help with your application:

**1-800-560-6420  
TTY - 1-866-325-4949**

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

# **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.**"

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"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.**"

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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 \$
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C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- |  |   |
|--|---|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.   | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements. |
| <input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.               |
| <input type="checkbox"/> Other: _____  |   |

## 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 TO 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 ____/____/____ Month Day Year		10. AGE ____ <input type="checkbox"/> Female <input type="checkbox"/> Male
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) ____-____-____ Home: (____) ____-____-____ (Area Code) (Area Code) Fax: (____) ____-____-____ Fax: (____) ____-____-____ (Area Code) (Area Code)			12. <b>REQUIRED</b> E-MAIL ADDRESS

**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 ☐ No2. NAME OF LAST PRELIMINARY SCHOOL  
ATTENDED3. 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 ☐ No6. COLLEGE OR UNIVERSITY NAME  
(Undergraduate and Graduate)LOCATION  
(City and State or Country)

DATES OF ATTENDANCE

FROM

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

TO

Did You Complete  
Training?

Month/Year

Month/Year

☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No



**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.)*

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

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	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												
b) CHART III - Select the examination site you desire and enter Test Center Code:	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> </table>												
c) CHART IV - Find your School of Graduation and enter school code:	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												
d) Record the number of times you have taken this exam in Illinois or any other state:	<table border="1"> <tr> <td></td><td></td> </tr> </table>												

PART VIII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)	
1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. <b>Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.</b>  Are you more than 30 days delinquent in complying with a child support order? (NOTE: If you are not subject to a child support order, answer "no.")	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>

PART IX: Certifying Statement	
Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.	
_____ Signature of Applicant	_____ Date
<b>I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.</b> 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.	

**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

3. PROFESSIONAL LICENSE NUMBER (if any)

2. ADDRESS STREET, CITY, STATE, ZIP CODE

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.**

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

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

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.

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for double-sided printing.**



O. THE PROGRAM WAS ACCREDITED BY THE COUNCIL FOR ACCREDITATION OF COUNSELING AND RELATED EDUCATIONAL PROGRAMS (CACREP), THE COUNCIL FOR REHABILITATION EDUCATION (CORE), OR THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) AT THE TIME THE PROGRAM WAS COMPLETED. ☐ YES ☐ NO

P. In the table below, list GRADUATE LEVEL coursework completed by the applicant in each of the required core areas. Include BOTH the UNIT of credit and the AMOUNT of credit awarded. For Semester Hours, abbreviate "SH". For Quarter Hours, abbreviate "QH". For all other units of credit please include information about conversion to semester hours. ( \_\_\_\_\_ = 3 semester hours.)

Do not include courses that do not fit the required core areas. If no course was completed in a specific core area, mark "NONE". If no credit was awarded, mark "ZERO".

Please refer to Rules 68 IAC Section 1375.Appendix A for more information about each core area.

Attach additional pages if necessary. Failure to complete this section of the application correctly may result in licensure delays for the applicant.

AREA	YEAR	COURSE NO.	COURSE TITLE	CREDIT AWARDED
Human Growth and Development				
Counseling Theory				
Counseling Techniques				
Group Dynamics, Processing and Counseling				
Appraisal of Individuals (Assessment)				
Research and Evaluation				
Professional, Legal & Ethical Responsibilities				
Social and Cultural Foundations				
Lifestyle and Career Development				
Practicum / Internship*				
* Completed at least 700 clock hours on-site including at least 280 hours direct client service.				YES / NO
Maladaptive Behavior & Psychopathology				
Addictions / Substance Abuse				
Family Dynamics				

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

\_\_\_\_\_  
Print Name of School Official

\_\_\_\_\_  
Signature of School Official

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

SCHOOL SEAL OR NOTARY SEAL

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

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Date of Expiration

\_\_\_\_\_  
Signature of Notary Public

**SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT**

NAME (Last, First, MI):

SSN OR ITIN:

Profession:



**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

## CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

# CT

**APPLICANT:** Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH ____ / ____ / ____ Month Day Year	3. SSN OR ITIN ____ - ____ - ____
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.  _____ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. APPLICANT TELEPHONE NUMBER (Daytime)  Area Code ( ____ ) ____ - ____	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize \_\_\_\_\_ to furnish to the Illinois Department of  
Name of Licensing Agency or Board  
Financial and Professional Regulation or its designated testing service, the information requested below.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### RETURN COMPLETED FORM TO APPLICANT

**LICENSING AGENCY:** The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

#### PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

\_\_\_\_\_  
Name of Examination Date of Examination

B. The applicant has or will have written the above-named examination \_\_\_\_\_ number of times.

#### PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER												
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE												
E. LICENSURE METHOD <input type="checkbox"/> Examination (Administered in Your State) <input type="checkbox"/> National (Name) _____ <input type="checkbox"/> State Constructed _____ <input type="checkbox"/> Other (Name) _____ <input type="checkbox"/> Endorsement of License (State) _____ Acceptance of Examination Results _____ (Administered in Another State) <input type="checkbox"/> Reciprocity with (State) _____ <input type="checkbox"/> Waiver/Grandfather _____ <input type="checkbox"/> Credentials _____ <input type="checkbox"/> Other (Describe) _____													
F. CURRENT LICENSURE STATUS <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain) _____ _____ _____	G. IF LICENSED BY EXAMINATION, RECORD SCORES <table><tr><td>Type of Examination</td><td>Score</td></tr><tr><td>Written</td><td>_____</td></tr><tr><td>Practical</td><td>_____</td></tr><tr><td>Other (Describe) _____</td><td>_____</td></tr><tr><td colspan="2">Received no Grade Below _____</td></tr><tr><td colspan="2">Examination Period ____ days ____ hours</td></tr></table>	Type of Examination	Score	Written	_____	Practical	_____	Other (Describe) _____	_____	Received no Grade Below _____		Examination Period ____ days ____ hours	
Type of Examination	Score												
Written	_____												
Practical	_____												
Other (Describe) _____	_____												
Received no Grade Below _____													
Examination Period ____ days ____ hours													

**PART III - CERTIFICATION OF EXAMINATION SCORES****A1. National or other Profession Specific Examination**  
(Record all available information)

Date of Examination \_\_\_\_\_

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

**A 2.**

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

**B. State Constructed Examination**

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

**PART IV - FORMAL ACTIONS**A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☐ NoB. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☐ No**PART V - RECIPROCAL REGISTRATION**This state ☐ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

S E A L

_____
Print Name
_____
Title
_____
Agency/Board Street Address
_____
City, State, ZIP Code

_____
Signature
_____
Date
Area Code ( _____ )
_____
Telephone Number

**Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.****Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.**

<p><b>IMPORTANT NOTICE:</b> Completion of this form is necessary for consideration for licensure under 225 ILCS 107/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.</p>	<h2 style="margin: 0;">PROFESSIONAL COUNSELOR VERIFICATION OF SUPERVISION &amp; EXPERIENCE</h2>	<p>SUPPORTING DOCUMENT</p> <h1 style="margin: 0;">VE-LCPC</h1>
<p><b>APPLICANT:</b> Complete the applicant section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary if you had multiple sites and/or multiple supervisors.</p> <p style="text-align: center;"><b>One year of full-time experience equals 1680 clock hours obtained in not less than 52 weeks.</b></p>		
1. NAME      LAST                      FIRST                      MIDDLE	2. DATE OF BIRTH ____ / ____ / ____ Month      Day                      Year	3. SSN OR ITIN ____ - ____ - ____
4. ADDRESS    STREET, CITY, STATE, ZIP CODE	<h3>180 Licensed Clinical Professional Counselor</h3>	
5. MAIDEN OR GIVEN SURNAME		
FOLLOWING SHOULD REFLECT INFORMATION AT TIME OF EMPLOYMENT/EXPERIENCE		
6. SUPERVISOR NAME	7. BUSINESS/INSTITUTION NAME	
8. SUPERVISOR TITLE	9. ADDRESS    STREET, CITY, STATE, ZIP CODE	
<p><b>SUPERVISOR:</b> Complete the remainder of this form. <u>RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT IN A SEALED ENVELOPE.</u></p>		
<b>PART I. - SUPERVISION INFORMATION</b>		
A. IMMEDIATE/DIRECT SUPERVISOR'S NAME	B. PROFESSIONAL DESIGNATION                      Date Awarded	
C. LICENSE NUMBER	<input type="checkbox"/> Licensed Clinical Professional Counselor                      ____	
D. STATE OF LICENSE	<input type="checkbox"/> Licensed Clinical Social Worker                      ____	
E. BUSINESS/INSTITUTION NAME	<input type="checkbox"/> Licensed/Registered Clinical Psychologist                      ____	
F. BUSINESS ADDRESS    STREET, CITY, STATE, ZIP CODE	<input type="checkbox"/> Psychiatrist                      ____	
G. BUSINESS TELEPHONE NUMBER Area Code ( ____ )    ____ - ____		
H. SUPERVISOR'S EMAIL ADDRESS		
<b>PART II. - APPLICANT EMPLOYMENT INFORMATION</b>		
A. APPLICANT'S JOB TITLE AT TIME OF EMPLOYMENT/ EXPERIENCE	B. DATES OF APPLICANT'S EMPLOYMENT/EXPERIENCE From ____ / ____ / ____ To ____ / ____ / ____ Month      Day                      Year                      Month      Day                      Year	
C. NUMBER OF HOURS APPLICANT WORKED PER WEEK	D. NUMBER OF HOURS YOU MET WITH THE APPLICANT PER WEEK	

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

**PART II. - APPLICANT EMPLOYMENT INFORMATION (Continued)**

E. INDICATE YOUR OVERALL EVALUATION OF THE APPLICANT'S PERFORMANCE UNDER YOUR DIRECT SUPERVISION

The experience was conducted in accordance with Rules 68 IAC Section 1375.130. ☐ YES ☐ NO

The applicant's performance was satisfactory or better. ☐ YES ☐ NO

F. CLOCK HOURS:

TOTAL CLOCK HOURS IN EXPERIENCE: \_\_\_\_\_

TOTAL CLOCK HOURS OF DIRECT FACE TO FACE IN PERSON SERVICE TO CLIENTS: \_\_\_\_\_

G. COMMENTS ABOUT APPLICANT'S JOB PERFORMANCE:

The above indicated experience has been performed by the applicant pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title