INSTRUCTION SHEET

Physician Reinstatement of a License that has been Expired or Inactive for 3 years or less.

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.

STEP I - Application

1. An **APPLICATION FOR REINSTATEMENT PHYSICIAN ONLY APPLICATION** completed in its entirety.

2. **HEALTH CARE WORKERS ADDITIONAL PERSONAL HISTORY QUESTIONS (PHQ)** Form completed in its entirety.

3. **Continuing Medical Education (CME)** You must provide documentation verifying 150 hours of CME. All CME hours must have been completed within 3 years prior to the signature date on your Request for Reinstatement/ Late Renewal.

    a. At least 60 hours must be obtained in formal CME programs as described in Section 1285.110 (b)(2) of the Administrative Rules. This must include one (1) hour in the topic of sexual harassment prevention training,and one (1) hour in the topic of implicit bias awareness training. Also, licensees who provide health care services to, and have direct interactions with patients who are 26 years of age or older must include one (1) hour in the diagnosis, treatment, and care of individuals with Alzheimer's disease and other dementias. A printed certificate or online CME tracker must be provided to document attendance or participation in formal CME programs.

    b. A maximum of 90 hours may be obtained in informal CME as described in Section 1285.110 (b)(3) of the Administrative Rules. Informal CME must be documented by the licensee providing a signed and dated statement describing the activity, the number of informal CME hours claimed for completing the activity, and the date that the activity was completed.

Note: Section 1285.110 a) 4 of the Administrative Rules states that, "A renewal applicant shall not be required to comply with CME requirements for the first renewal of an Illinois license." So, if July 31, 2023, was the first license renewal after your physician license was initially issued, then you are not required to provide documentation of 150 CME hours for reinstatement/late renewal of your physician license.

4. Note: The Application For State Controlled Substances Registration and instructions can be found at the end of this packet to use when applying for an Illinois controlled substances registration.

    Prescribers with Controlled Substances Registrations must verify completion of three (3) CME hours in the topic of safe opioid prescribing practices for each controlled substance license renewal. There is no exemption allowed for the first renewal. So, you must provide documentation of 3 CME hours in safe opioid prescribing practices for reinstatement/late renewal of your controlled substance license.

STEP II - Fee

Identify the fee to reinstatement your license by using the Restoration/Reinstatement Fee Calculator. Payment must be in the form of a check or money order payable to IDFPR, or by submitting a payment online using the ePay Portal at: ***https://idfpr.illinois.gov/epay.html***

STEP III - Mail Application

Mail your application for reinstatement, supporting documents and payment to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
PO Box 7450
Springfield, IL 62791

Need Assistance

If you need assistance, please contact the Department of Financial and Professional Regulation at:

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

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Request for Reinstatement/Late Renewal: Physicians Only

Note: This form is only applicable to physician licenses that expired on July 31, 2023.

PLEASE PRINT

Physician License #: **036.**_____ Controlled Sub License # (if applicable): **336.**_____

SSN (Last four only) or ITIN: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

☐ **CHECK HERE IF NAME OR ADDRESS CHANGE.**

A name change must be accompanied by documentary proof. Proof must be a certified copy with an official stamp or seal and be one of the following: Marriage Certificate, Divorce Decree or Court Order.

☐ I consent to professional organizations having my email address.

LICENSE RENEWAL QUESTIONS: You must respond to ALL the following questions to reinstate your license. Failure to answer ALL these questions will result in the form(s) being returned to you for proper completion.

Since July 31, 2017, do you now have any disease or condition that impairs or impaired your ability to perform the essential functions of your profession, including any disease of 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 explanation including dates, names and addresses of treating physicians and/or counselors and nature of treatment.

☐ YES ☐ NO

Since July 31, 2017, 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.

☐ YES ☐ NO

Since July 31, 2017, have your clinical, hospital or practice privileges been restricted, suspended, or revoked, or have you submitted a resignation or not renewed clinical, hospital or practice privileges while under investigation (other than for non-completion of medical records)? If yes, attach a detailed explanation. ☐ YES ☐ NO

Since July 31, 2017, has any action been taken on your Drug Enforcement Administration (DEA) Registration, including but not limited to surrender, revocation, or entry of memorandum of agreement? ☐ YES ☐ NO

Have you been convicted of or are you currently charged with any criminal offense in any state or federal court (other than minor traffic violations) that you have not previously reported to this Department? ☐ YES ☐ NO

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

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?

☐ YES ☐ NO

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

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

If YES to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.

CHECK THE APPROPRIATE ANSWER BELOW:

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

4. Do you certify you have fully complied with this profession’s continuing education requirements? ☐ Yes ☐ No

   NOTE: Continuing education is not required for the first renewal of this license. If this is your first renewal, please answer (Yes) to this question.

   Making a false statement may subject the licensee to disciplinary action.

   You may verify the continuing education requirements of your profession here: https://idfpr.illinois.gov/rules2015.html

INCOMPLETE REINSTATEMENT: Incomplete forms will be returned and result in a substantial delay in the reissuance of your license. Please assure your reinstatement includes the following:

- Fee must be a check or money order, payable to the Illinois Department of Financial and Professional Regulation. Do not mail cash (see attached reference chart).
- Include proof of 150 hours of CME (if applicable, see attached reference chart).
- Include proof of 3 hours of CE for safe opioid prescribing for Controlled Substance License.

Payment Method

☐ Check / Money Order. Check Number: _____

☐ Online. Paid Online at:***https://idfpr.illinois.gov/epay.html*** in the amount of _____. Approved #:_____

I understand if I provide false or fraudulent information, I could lose my license, be fined and/or be assessed other penalties. I also understand the FEES ARE NOT REFUNDABLE. Therefore, I declare that I have examined this form, and to the best of my knowledge, all statements are true, correct and complete.

Signature: _____ 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 _____

INSTRUCTION SHEET

Controlled Substances Registration

IMPORTANT NOTICE: Every person who prescribes, dispenses, or stores any controlled substances within the State of Illinois must obtain a registration issued by the Department of Financial and Professional Regulation in accordance with Section 302 of the Illinois Controlled Substances Act [720 ILCS 570].

A separate registration is required for each place of business or professional practice where controlled substances are located, stored, or dispensed. A separate registration is not required at each place of business or professional practice where a registrant prescribes controlled substances.

Use the **Application for State Controlled Substances Registration** when applying for a new controlled substances registration **OR** when applying for reinstatement of an existing controlled substances registration to active status. Reinstatement applications must include proof of three (3) continuing medical education hours in the topic of safe opioid prescribing practices.

> NOTE: If you were issued a controlled substances registration in the past, you are required to apply for reinstatement of that registration prior to applying for a new registration. Please visit the department's website at https://idfpr.ilinois.gov to check your Illinois controlled substances registration information.

Step I - Application

1. Submit a completed APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION - This must include the street address for your place of business or professional practice in Part II, 4 if you will be storing or dispensing controlled substances, including samples. A controlled substances registration will not be issued to a P.O. Box. For reinstatement applications, you must include the 9-digit controlled substances registration number in Part I, 3 for the registration that you are reinstating to active status. The registration number begins with 336.

2. Submit a completed **Health Care Workers Additional Personal History Questions (PHQ)**.

3. 3. For reinstatement applications, submit a copy of your certificate verifying completion of three (3) CME hours in the topic of safe opioid prescribing practices.

STEP II - Fee

The fee for a new controlled substances registration is $5. The fee for reinstatement of a controlled substances registration is $15. Payment must be the form of a check or money order payable to IDFPR, or by submitting a payment online using the ePay Portal at: ***https://idfpr.illinois.gov/epay.html***.

STEP III - Mail Application

Mail your application for reinstatement, supporting documents, and payment to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
PO Box 7450
Springfield, IL 62791

Need Assistance

If you need assistance, please contact The Department of Financial and Professional Regulation at:

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

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APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

Disclosure of your U.S. social security number, if you have one, is ***mandatory***, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box		3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist	☐346 Optometrist	☐ New Registration	$5
	☐316 Podiatrist	☐390 Veterinarian	☐ Reinstatement	$15
	☐336 Physician	☐377 APRN-FPA	☐ Registration #: _____	

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., M.D., O.D., etc.)

3. SSN OR ITIN

__ __ __ – __ __ – __ __ __ __

4. BUSINESS NAME AND ADDRESS (P.O. Boxes are not acceptable) CITY STATE/COUNTRY ZIP CODE COUNTY

5. PERMANENT ADDRESS (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED

6. EMAIL ADDRESS (REQUIRED)

☐ I consent to professional organizations having my email address.

7. STORING OR DISPENSING

☐ **No, I will not be** storing or dispensing controlled substances, including samples at the address in Part II, 4.

☐ **Yes, I will be storing or dispensing** controlled substances, including samples at the address in Part II, 4.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work ( ) _____ **FAX** ( ) _____
Area Code Area Code

Home ( ) _____ **FAX** ( ) _____
Area Code Area Code

PART IV: Drug Schedule

Circle each schedule that you are applying for:

II III IV V

PART V: Professional Activity

Practitioner--Check and complete one of the following:

	Professional License Number
☐ Dentist	019 - _____
☐ Optometrist	046 - _____
☐ Physician	036 - _____
☐ Podiatrist	016 - _____
☐ Veterinarian	090 - _____
☐ APN-FP	277 - _____

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.		
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

PART III: Child Support, Tax Information, 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 ☐

4. Do you certify you have fully complied with this profession's continuing education requirements? Yes ☐ No ☐

   NOTE: Continuing education is not required for the first renewal of this license. If this is your first renewal, please answer (Yes) to this question.
   Making a false statement may subject the licensee to disciplinary action.
   You may verify the continuing education requirements of your profession here: https://idfpr.illinois.gov/rules2015.html

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge. **I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.**

Payment Method

☐ Check / Money Order. Check Number: _____

☐ Online. Paid Online at: ***https://idfpr.illinois.gov/epay.html*** in the amount of _____. Approved #:_____

_____ Date of Application

_____ Signature of Applicant

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI):

SSN OR ITIN:

Profession: