INSTRUCTION SHEET

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

Please visit the department's website at ***https://idfpr.illinois.gov*** to check your license information.

There are two ways to reinstate your physician license:

1) If your application is based upon active PRACTICE as a licensed physician in another state within the 3 years immediately preceding this application.

OR

2) If you have NOT been actively practicing as a licensed physician in another state within the 3 years immediately preceding this application, you can register to take the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards (FSMB) or provide evidence of the requirements contained in 68 IAC 1285.130 (c) (1), (2), (3), or (4).

STEP I - Application

A. Submit each of the following if you HAVE BEEN actively practicing as a licensed physician in another state within the 3 years immediately preceding this application:

1. **APPLICATION FOR RESTORATION** completed in its entirety.
2. **PERSONAL HISTORY INFORMATION (PH)** Form completed in its entirety.
3. **HEALTH CARE WORKERS ADDITIONAL PERSONAL HISTORY QUESTIONS (PHQ)** Form completed in its entirety.
4. **Continuing Medical Education (CME)**
   a. Proof that you have completed 150 hours of CME obtained within the 3 years immediately preceding the date of your Illinois restoration application.
   b. This must include 1 hour of Category 1 CME in the topic of sexual harassment prevention training and 1 hour of Category 1 CME in the topic of recognizing implicit bias in health care.
   c. In addition, physicians who provide health care services to, and have direct patient interactions with, individuals who are 26 or older must include 1 hour of category 1 CME focused on the diagnosis, treatment, and care of individuals with Alzheimer's disease and other dementias.
      i. Category 1 CME hours may be verified by submitting a printed certificate or online CME tracker to document attendance or participation in a formal CME program.
      ii. Category 2 CME hours may be verified by submitting a signed and dated statement that describes the activity, the number of informal CME hours claimed for completion of the activity, and the date that the activity was completed.
5. **Verification of Employment Form (VE)** completed in its entirety - This form must be completed by your employer verifying that you have practiced as a licensed physician in another state within the 3 years immediately preceding the date of your Illinois restoration application.
6. **Certification By Licensing Agency/Board (CT)** Form completed in its entirety. Submit an official verification of licensure issued by the state board where you have been practicing as a licensed physician within the 3 years immediately preceding the date of your Illinois restoration application. The state board may use the department's CT form or issue their own official verification.
7. 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.

B. If you have not practiced as a licensed physician in another state within the 3 years immediately preceding the date of your Illinois reinstatement application, you must complete the following:

1. **APPLICATION FOR RESTORATION** completed in its entirety.

2. You will need to take the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards (FSMB). Please indicate this by checking the examination box on Section IV (Statement of Restoration Method) on the Restoration Application or provide evidence of the requirements contained in 68 IAC 1285.130 (c) (1), (2), (3), or (4).

3. **PERSONAL HISTORY INFORMATION (PH)** Form completed in its entirety.

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

5. **Continuing Medical Education (CME)**
   a. Proof that you have completed 150 hours of CME obtained within the 3 years immediately preceding the date of your Illinois restoration application.
   b. This must include 1 hour of Category 1 CME in the topic of sexual harassment prevention training and 1 hour of Category 1 CME in the topic of recognizing implicit bias in health care.
   c. In addition, physicians who provide health care services to, and have direct patient interactions with, individuals who are 26 or older must include 1 hour of category 1 CME focused on the diagnosis, treatment, and care of individuals with Alzheimer's disease and other dementias.
      i. Category 1 CME hours may be verified by submitting a printed certificate or online CME tracker to document attendance or participation in a formal CME program.
      ii. Category 2 CME hours may be verified by submitting a signed and dated statement that describes the activity, the number of informal CME hours claimed for completion of the activity, and the date that the activity was completed.

6. If taking the Special Purpose Examination (SPEX), after the department has received your Illinois restoration application, PH Form, PHQ Form, and CME completed in their entirety and received, the department will email you a notification to register for SPEX. After the examination takes places and is scored the Federation of State Medical Boards (FSMB) will forward an official score report to the department as a verification of your SPEX results. A passing score on the SPEX is required for the department to approve issuance of your Illinois physician 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 restoration, 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

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."**

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.

APPLICATION FOR RESTORATION

SUPPORTING DOCUMENT

REST

APPLICANT: Complete this form, and **return it with the supporting documents and required payment.**

PART I: Application Category Information

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.

PART II: Application Identifying Information

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month / Day / Year)

3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __

4. TELEPHONE NUMBER

WORK (__ __ __) __ __ __ – __ __ __ __ (Area Code) HOME (__ __ __) __ __ __ – __ __ __ __ (Area Code)

5. E-MAIL ADDRESS

☐ I consent to professional organizations having my email address.

6. ADDRESS STREET, CITY, STATE, ZIP CODE

7. Record profession name and three digit profession code for which you are making Illinois application.

_____ (Profession Name) ___ ___ ___ (Profession Code)

8. MAIDEN OR GIVEN SURNAME

9. NAME AS IT APPEARS ON EXPIRED/INACTIVE LICENSE

10. ISSUANCE DATE OF EXPIRED OR INACTIVE LICENSE

11. DATE EXPIRED OR PLACED INACTIVE

12. EXPIRED OR INACTIVE LICENSE NUMBER

OFFICIAL USE ONLY

License No.: _____ Fees: $ _____

Issuance Date: _____ On CRT: ☐Yes ☐No

PART III: Record of Licensure Information

LIST THE STATE(S) AND DATES WHERE YOU HAVE BEEN PRACTICING SINCE YOUR ILLINOIS LICENSE EXPIRED OR WAS PLACED ON INACTIVE STATUS. INCLUDE A BRIEF DESCRIPTION OF DUTIES PERFORMED.

STATE	NAME OF BUSINESS/INSTITUTION	DATES From Mo/Yr	DATES To Mo/Yr	DESCRIPTION OF DUTIES

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

PART IV: Statement of Restoration Method

Please refer to your restoration directions to determine if you need to complete this section.

If you are unable to restore your license based on lawful practice in another jurisdiction, then you must notify the Department that you wish to complete a refresher course or take and pass the Illinois exam that is specific to your profession.

Choose one of the options below, if applicable.

☐ I wish to take a refresher course specific to my profession. I will submit an official transcript from an approved school verifying successful completion of the required hours of instruction in the basic curriculum for the professional license I wish to restore. I understand that Illinois schools must be licensed by the Department and schools located outside of Illinois must be recognized and authorized to operate in the jurisdiction where the school is located.

☐ I wish to take the required examination specified in my profession's rules. I understand that upon receipt and processing of my restoration application, the Department will forward my application to the testing service. The Department will also e-mail to me an approval letter authorizing me to take the examination and providing instructions to register for the examination. DO NOT SUBMIT AN APPLICATION TO THE TESTING SERVICE UNTIL YOU ARE NOTIFIED BY THE DEPARTMENT.

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

	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

PART VI: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☐
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes? Yes ☐ No ☐

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 VIII: 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.**

Payment Method

☐ Check / Money Order. Check Number: _____

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

_____ _____

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 _____

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

SUPPORTING DOCUMENT

VE

APPLICANT: ***Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. 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. JOB TITLE OR POSITION APPLICANT HELD	
8. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ To __ __ /__ __ /__ __ __ __ Month Day Year Month Day Year	9. SUPERVISOR NAME	

EMPLOYER: ***Complete the remainder of this form. Return the completed form to the applicant in a sealed envelope.***

PART I - EMPLOYMENT INFORMATION

A. EMPLOYER NAME		B. BUSINESS / INSTITUTION NAME
C. EMPLOYER REGISTRATION/LICENSE NUMBER	D. STATE OF EMPLOYER REGISTRATION/LICENSE	E. BUSINESS ADDRESS STREET CITY STATE ZIP CODE
F. BUSINESS REGISTRATION/LICENSE NUMBER (If Applicable)	G. STATE OF BUSINESS REGISTRATION/LICENSE	H. BUSINESS TELEPHONE NUMBER Area Code (___ ___ ___) ___ ___ ___-___ ___ ___ ___

PART II - APPLICANT EMPLOYMENT INFORMATION

A. NUMBER OF HOURS WORKED PER WEEK	B. TYPE OF EMPLOYMENT [ ]Full-time [ ]Part-time	C. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ To __ __ /__ __ /__ __ __ __ Month Day Year Month Day Year

D. RECORD APPLICANT'S POSITION TITLE(S)

E. GIVE BRIEF DESCRIPTION OF DUTIES PERFORMED BY THE APPLICANT.

I do hereby declare that this information is true and correct.

_____
Signature

_____ _____
Date Title

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

☐ Examination (Administered in Your State)
- ☐ National (Name) _____
- ☐ State Constructed _____
- ☐ Other (Name) _____

☐ Endorsement of License (State) _____

Acceptance of Examination Results _____
(Administered in Another State)

☐ Reciprocity with (State) _____
☐ Waiver/Grandfather
☐ Credentials
☐ Other (Describe) _____
_____
_____

F. CURRENT LICENSURE STATUS	G. IF LICENSED BY EXAMINATION, RECORD SCORES
☐ Active ☐ Inactive ☐ Lapsed ☐ Other (Explain) _____ _____ _____	Type of Examination Score Written _____ Practical _____ Other (Describe) _____ _____ Received no Grade Below _____ Examination Period _____ days _____ hours

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

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 ☐ No

B. 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.

SEAL

Print Name

Title

Signature

Agency/Board Street Address

Date

Area Code ( )

City, State, ZIP Code

Telephone Number

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

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

This page intentionally left blank for double-sided printing.

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: